Supreme Court, U.S.
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No. _____

IN THE

# Supreme Court of the United States

OCTOBER TERM, 1993

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ABBAS ASSAR, M.D.,
*Petitioner,*

v.

CRESCENT COUNTIES FOUNDATION FOR MEDICAL CARE

and

CENTRAL ILLINOIS MEDICAL REVIEW ORGANIZATION,
*Respondents.*

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**Petition for a Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit**

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## PETITION FOR A WRIT OF CERTIORARI

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## QUESTION PRESENTED

This case involves a *Bivens* claim.

A *Bivens* remedy allows individuals whose constitutional rights have been violated by federal officers to sue for money damages in federal court. The question presented is:

Is a *Bivens* remedy available to an individual whose constitutional rights are violated when a federal agency obstructs the administrative review process and fails to comply with statutory agency requirements, thus preventing that individual from having administrative and judicial review?

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Petitioner, Abbas Assar, M.D., prays that the Supreme Court of the United States grant a writ of certiorari to review the judgment of the United States Court of Appeals for the Seventh Circuit which affirmed the District Court's dismissal of Petitioner's suit based on lack of subject matter jurisdiction.

## OPINIONS BELOW

U.S. Court of Appeals for the Seventh Circuit Opinion, Appendix A (1a). U.S. District Court, Central District of Illinois, Appendix B (12a). Denial of Petition for Rehearing, Appendix C (22a).

## JURISDICTION

The United States Court of Appeals for the Seventh Circuit entered its judgment on December 29, 1993 (Appendix 1a). The Court of Appeals denied a timely petition for rehearing on March 9, 1994 (Appendix 22a).

The case arose under the Fifth Amendment of the United States Constitution and the District Court had jurisdiction under 28 U.S.C. § 1331. The jurisdiction of this Court is invoked under 28 U.S.C. § 1257(a).

## STATUTES

42 U.S.C. § 1320c-5b(1):

> If, after reasonable notice and opportunity for discussion with the practitioner or person concerned, any organization having a contract with the Secretary under this part determines that such practitioner or person has—
>
> > (A) failed in a substantial number of cases substantially to comply with any obligation imposed on him under subsection (a) of this section, or
> >
> > (B) grossly and flagrantly violated any such obligation in one or more instances, such organization shall submit a report and recommendations to the Secretary. If . . .

28 U.S.C. § 1361:

> The district courts shall have original jurisdiction of any action in the nature of mandamus to compel an officer or employee of the United States or any agency thereof to perform a duty owed to the Plaintiff.

42 C.F.R. § 1004.50-1004.90:

> See Appendix D, pg. 23a.

## STATEMENT OF THE CASE

Petitioner, Abbas Assar, M.D., is a physician. Respondent, Crescent Counties Foundation for Medical Care, and Respondent, Central Illinois Medical Review Organization, are peer review organizations (PRO's). Respondents are under contract with the Health Care Financing Administration ("HCFA") to review the medical care provided by physicians and hospitals participating in the Medicare program. PRO's review the medical services provided to Medicare patients by physicians to assure that the services will be of a quality which meets professionally recognized standards of health care.

Respondents reviewed the medical care which Petitioner provided to a Medicare patient and alleged his care of the patient was of poor quality and the treatment constituted a "gross and flagrant violation" of his duties under the Medicare program. Thereafter, Respondents limited and restricted Petitioner's ability to care for Medicare patients. The statutes and regulations set out by Congress which govern PRO's have an elaborate step-by-step procedure mandating how the PRO is to proceed when an alleged gross and flagrant violation is identified. The PRO's refused to follow the statutes and regulations. See 42 U.S.C. § 1320c-5(b) (see Statutes pg. 2); 42 C.F.R. §§ 1004.50-1004.90 (Appendix pg. 23a). These regulations include an extensive appeal process available to an involved physician including a hearing before an administrative law judge and judicial review.

The PRO refused to follow the regulations set forth by Congress and instead embarked on its own pathway. This pathway prevented the Petitioner from gaining access to Congress' appeals scheme. Among other things, they did not provide Assar with written notice as required by 42 C.F.R. § 1004.50 (Appendix pg. 23a) and did not submit a report to the Office of the Inspector General (OIG) as required by 42 C.F.R. § 1004.70 (Appendix pg. 24a). The refusal to submit the report to the OIG and the failure

to provide written notice deprived Petitioner of his due process rights under the administrative scheme. The failure to submit the report to the OIG prevented the OIG from determining if the PRO had followed its procedures and from determining if a violation had actually occurred. 42 C.F.R. § 1004.90(b) (Appendix pg. 25a). Petitioner was never informed of any appeal rights and since the OIG had never made a determination he did not gain his right to administrative review. This prevented the administrative review process from going forward and prevented Dr. Assar from appealing the PRO allegations and penalties.

Petitioner filed suit in District Court asserting, among other things, a Fifth Amendment due process claim and attempted to recover under a *Bivens* claim. The District Court dismissed the case finding that the "Social Security Act" includes detailed statutory mandates providing for several levels of administrative review of the actions of the PRO's and the sanctioning of a Medicare provider (Appendix B pg. 12a). The Court suggested that Petitioner file a federal mandamus action under 28 U.S.C. § 1361 to compel the PRO's to comply with the statutes and regulations which Congress set up.

The U.S. Court of Appeals for the Seventh Circuit affirmed the dismissal finding that since Congress had "created a comprehensive scheme by which physicians can obtain review of PRO decisions," a *Bivens* remedy was unavailable (Appendix A pg. 1a). The Court suggested that Petitioner could have sought relief under 28 U.S.C. § 1361 to force the PRO to follow Congress' regulations and allow him his administrative appeal rights.

## REASONS FOR GRANTING WRIT

This case involves a *Bivens* claim which is based on the premise that individuals whose constitutional rights have been violated by federal officers can sue for money damages. *Bivens v. Six Unknown Named Agents of the Federal Bureau of Narcotics*, 403 U.S. 388 (1971).

Petitioner did not want to file a *Bivens* claim against Respondents. The only thing that Petitioner wanted was to appeal Respondents' decision to restrict his ability to care for Medicare patients. Petitioner, from the outset, merely wanted to follow the procedures that Congress set up which allow a physician to appeal an adverse PRO decision. Respondents refused to allow him to do so. Forcing Respondents to follow Congress' theme at this point is moot. Respondents have already notified hospitals and individuals that Petitioner is a "bad doctor." Respondents have restricted his ability to care for Medicare patients. Dr. Assar's medical practice is all but ruined. This was all done in direct violation of the rules and regulations that Congress set up.

The issue involved in this case has divided the U.S. Court of Appeals for the Seventh Circuit, the Eighth Circuit in *Glasgow v. United States Drug Enforcement Administration*, 12 F.3d 795 (1993), and the U.S. Court of Appeals for the Federal Circuit in *Ysasi v. Rivkind*, 856 F.2d 1520 (Fed. Cir., 1988). The outcome of this case has the potential to affect every person in the United States. Anyone who deals with the government or any federal agency can be adversely affected if the Seventh Circuit's decision is allowed to stand.

Congress has set up hundreds of federally authorized agencies to help administer all of the social programs that society makes available to its citizens. Most of the programs, if not all of them, include an extensive framework of appeals that allow a citizen dealing with that agency the opportunity to appeal a decision that he or she feels is unjust or adversely affects him or her. Congress is

generally very careful to afford each citizen multiple chances to appeal an adverse agency decision. The problem in our case involves an agency which chose to ignore the rules, regulations, and statutes that Congress has enacted. *Ysasi v. Rivkind,* 856 F.2d 1520 (Fed. Cir. 1988) dealt with issues very similar to ours. The *Ysasi* decision is in direct conflict with the decision of Petitioner's case.

In *Ysasi,* a migrant farm worker, Ysasi, had his truck confiscated by Border Patrol agents. He attempted to recover his truck by filing an administrative appeals claim with the Immigration and Naturalization Service (INS). Although Congress had set forth a comprehensive statutory and regulatory scheme to allow individuals like Ysasi to challenge the validity of an improper seizure, the INS ignored that scheme and improperly sold his truck. *Id.* at 1528. The INS prevented Ysasi from utilizing the available procedures which Congress had set forth to obtain the return of his truck. The Court allowed a *Bivens* claim since the INS had failed to follow Congress' comprehensive statutory and regulatory scheme.

Our circumstance is very similar to the *Ysasi* case. As in that case, Petitioner was adversely affected by an agency that chose to ignore Congress' regulations. A federally authorized agency chose to ignore the comprehensive statutory and regulatory scheme that Congress had developed to allow physicians to challenge an adverse PRO decision. The Seventh Circuit Court of Appeals held that since Congress had created a comprehensive scheme by which physicians could obtain review of PRO decisions, then a *Bivens* claim was unavailable. The Court ignored the fact that Petitioner was never allowed to access the comprehensive scheme.

In *Glasgow v. United States Drug Enforcement Administration,* 12 F.3d 795 (1993), the Eighth Circuit also addressed a similar issue. A claimant whose money was forfeited brought a *Bivens* action against the Drug Enforcement Administration (DEA), and others, claiming

violation of his constitutional rights. Among other things, claimant alleged that the DEA did not comply with Congress' statutory and constitutional notice requirements. The Eighth Circuit refused to uphold the dismissal of a *Bivens* claim. They noted that the DEA's compliance with the statutory notice requirements were essential components of Congress' statutory regime. *Id.* at 797. The Agency's actions reflected an attitude of concealment rather than enlightenment, and did not meet the basic demands of due process. *Id.* at 798.

The crux of Petitioner's case is that a federal agency cannot completely ignore Congress' comprehensive scheme which mandates how that agency functions and then escape a *Bivens* claim. The U.S. Court of Appeals for the Federal Circuit and the Eighth Circuit allow a *Bivens* claim in such circumstances. The Seventh Circuit's opinion does not allow a *Bivens* claim under the same circumstances.

Congress is authorized with the power to set up federal agencies. They usually enact a detailed step-by-step remedial system to provide individuals with a mechanism to appeal constitutional violations that may occur in the course of agency administration. Millions of private individuals are affected by hundreds of federal agencies. A series of Post-*Bivens* cases that are distinguishable from Petitioner's case have addressed *Bivens* claims.

*Schweiker v. Chilicky,* 487 U.S. 412 (1988), dealt with a plaintiff who had been denied social security benefits and was attempting to recover damages for alleged due process violations. The Plaintiff chose not to utilize the appeals process which Congress had set up for individuals who had been denied benefits. The Court noted that the Social Security Act provided a multi-step framework of appeals available to individuals who had suffered alleged constitutional violations and thus refused to create a *Bivens* remedy. The Court reasoned that the Plaintiff could utilize the Congressional framework of appeals since it was available.

*Hilst v. Brown,* 874 F.2d 725 (10th Cir., 1989) (per curiam), involved a physician seeking damages for due process violations that had occurred when he was suspended from the Medicare program. A *Bivens* claim was not allowed because a comprehensive remedy was available to the suspended physician including an administrative and judicial review of his suspension.

The Plaintiffs in both *Chilicky* and *Hilst* could utilize an extensive appeals process which Congress had set up. Our Petitioner could not.

The importance of our case hinges on the fact that federal agencies must be required to follow the statutes and regulations that Congress enacts. We cannot have agencies arbitrarily disregarding Congress' rules and procedures. *Chilicky* pointed out it is appropriate for a federal agency to be shielded from a *Bivens* claim if the agency follows the regulatory framework Congress has outlined. Petitioner argues it is *not* appropriate to give the same agency immunity from a *Bivens* claim if they choose to arbitrarily ignore that regulatory framework. Federal agencies should not be able to deliberately abuse their governmental power, ignore federal statutes and regulations, violate the constitutional rights of citizens, and then escape *Bivens* liability.

As an example, hundreds of thousands of welfare recipients deal with federal agencies every day. Many of these recipients are indigent, uneducated, or disabled. Congress constructs federal agencies in a manner, at least in part, to protect citizen's rights. We cannot tolerate a system that allows an agency to arbitrarily disregard the rules and regulations that Congress enacts governing that agency, and then leave those welfare recipients with no recourse against the agency. If a federal agency violates the constitutional rights of a welfare recipient and ignores the framework that Congress enacts to protect those welfare recipients, then a *Bivens* claim should be available to

them. It is unrealistic to presume that these welfare recipients might bring a federal mandamus action under 28 U.S.C. § 1361 to compel an agency to follow their own rules, as the Appellate Court suggested in Petitioner's case. It is unrealistic to assume that these indigent, uneducated, or disabled individuals would be able to seek out an attorney, finance and orchestrate a federal mandamus action against a federal agency to compel the agency to do what it is already obligated to do . . . provide them with due process rights.

The Seventh Circuit, in giving its opinion, did not address the main issue in this case. That is, Petitioner was never allowed to access the comprehensive statutory and regulatory scheme which Congress had enacted. Respondents disregarded the procedures and regulations governing the PRO system and thereby denied Petitioner his due process right to administrative hearings as well as administrative and judicial review. Although an elaborate procedural framework existed, Petitioner could not access that framework due to Respondent's illegal actions. Both the District Court and the Appellate Court suggest that Petitioner could have sought relief under 28 U.S.C. § 1361, the federal mandamus action, to compel the agencies to follow the regulations. An individual should not be required to bring a federal mandamus action to protect his due process rights to an administrative review. They have ignored the fact that Petitioner's harm and damages had already occurrred. Compelling the agency to follow the rules at this point would be moot.

*Hilst,* 874 F.2d at 727-28, acknowledged that an elaborate administrative and judicial review was available to the Plaintiff and reasoned that "so long as the remedy, although incomplete, is adequate and the safeguards meaningful" then a *Bivens* action is unavailable. Petitioner argues that 28 U.S.C. § 1361 is not a "remedy" as referred to in *Bush v. Lucas,* 462 U.S. 367, 380 (1983), *Chilicky,* 487 U.S. at 425, or *Hilst,* 874 F.2d at 727-28.

The "remedy" is the elaborate administrative hearing, and administrative and judicial review which the Respondents prevented Petitioner from utilizing. Petitioner suggests that he had no meaningful safeguards available to protect his due process right to access Congress' comprehensive statutory and regulatory scheme.

Both the District Court and the Appellate Court relied heavily on *Chilicky*, 487 U.S. 412, determining that Congress has not failed to provide meaningful safeguards or remedies for the rights of persons situated as respondents were." *Id.* at 425. The problem with this reasoning, as pertains to our case, seems simple. Congress did construct a system which would normally protect individuals like Petitioner with meaningful safeguards and remedies. Respondent did not follow that system. Since Respondents arbitrarily ignored Congress' rules and regulations, Petitioner had no meaningful safeguards or remedies and Petitioner was never a participant in the comprehensive statutory scheme.

Similarly, *Hilst*, 874 F.2d 725 (10th Cir., 1989) (per curiam) was cited by the Appellate Court in support of its decision but in that case the Plainitff had the availability of administrative review. The Plaintiff had been suspended from the Medicare program and he utilized the extensive appeals process which Congress had constructed. Plaintiff was able to utilize Congress' appeals framework. Petitioner in our case was never able to do so. Even the Court in *Hilst* at 727 mentioned *Ysasi*, 856 F.2d 1520, acknowledging that a *Bivens* remedy was available despite *Chilicky* when utilization of statutory relief was "frustrated" by the Defendant.

## CONCLUSION

This case involves important issues which can affect millions of individuals who deal with federal agencies. The threat of a *Bivens* claim may be the only realistic mechanism to encourage federal agencies to follow the

rules which Congress enacts. Without that threat, agencies will have no incentive to do so. The U.S. Court of Appeals are now in conflict on this issue. The United States Supreme Court should decide this important matter.

Respectfully submitted,

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## APPENDIX A

IN THE UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

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No. 92-3678

ABBAS ASSAR, M.D.,
*Plaintiff-Appellant,*

v.

CRESCENT COUNTIES FOUNDATION FOR MEDICAL CARE and CENTRAL ILLINOIS MEDICAL REVIEW ORGANIZATION (CIMRO),
*Defendants-Appellees.*

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Appeal from the United States District Court for the Central District of Illinois, Danville Division
No. 92 C 2161—Harold A. Baker, *Judge*

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ARGUED MAY 12, 1993—DECIDED DECEMBER 29, 1993

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Before BAUER, KANNE and ROVNER, *Circuit Judges.*

ROVNER, *Circuit Judge.* Crescent Counties Foundation for Medical Care ("CCFMC") is a peer review organization ("PRO") under contract with the Health Care Financing Administration ("HCFA") to review the medical care provided by physicians and hospitals participating in

the Medicare program. *See* 42 U.S.C. §§ 1320c *et seq.*[1] Central Illinois Medical Review Organization ("CIMRO"), also a PRO, subcontracts with CCFMC to perform peer review services for HCFA.[2] Dr. Abbas Assar seeks damages from CCFMC and CIMRO, alleging that CIMRO failed to follow proper statutory and regulatory procedures when it found him in violation of certain quality of care requirements. The district court dismissed the suit for lack of subject matter jurisdiction, and we affirm.[3]

## I. Background

Health care providers who participate in the Medicare program are statutorily required to "assure" that their services:

> (1) will be provided economically and only when, and to the extent, medically necessary;
>
> (2) will be of a quality which meets professionally recognized standards of health care; and
>
> (3) will be supported by evidence of medical necessity and quality in such form and fashion and at such time as may reasonably be required by a reviewing peer review organization in the exercise of its duties and responsibilities.

42 U.S.C. § 1320c-5(a); *see also* 42 C.F.R. § 1004.10. PROs review the services of participating providers to insure compliance with these statutory obligations. Possible sanctions for non-compliance include exclusion from

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[1] Because CIMRO made the now-contested finding regarding Assar in August 1989, we will rely on the 1988 statute and regulations, which were in effect at that time.

[2] 42 U.S.C. § 1320c-2(c)(1) authorizes such subcontracting.

[3] Although some courts as well as the parties and the district court in this case have framed the issue as one of subject matter jurisdiction, other courts have understood it as failure to state a claim. Because the result is the same either way, the distinction is not significant.

the Medicare program. 42 U.S.C. § 1320c-5(b)(1); 42 C.F.R. § 1004.20; *see also* 42 U.S.C. § 1320c-2(c)(1).

The statute and regulations set out an elaborate procedure for finding non-compliance. *See* 42 U.S.C. § 1320c-5; 42 C.F.R. §§ 1004.30-1004.80. That process is set into motion when the PRO determines that a provider either has "failed in a substantial number of cases substantially to comply" with the statutory obligations or has "grossly and flagrantly violated any such obligation in one or more instances." 42 U.S.C. § 1320c-5(b)(1); *see also* 42 C.F.R. § 1004.30(c). Upon making that determination, the PRO must notify the provider in writing of both the basis for the determination and the proposed sanction. The provider then has thirty days to submit additional information or to request a meeting to discuss the PRO's determinaion (42 C.F.R. § 1004.50),[4] and the PRO may reconsider its decision in light of any additional information (42 C.F.R. § 1004.50(c)). If the PRO persists in its determination, it must submit a report and recommendation to the Office of the Inspector General ("OIG") (42 C.F.R. §§ 1004.60-1004.80) and must send the provider a copy of its report (42 C.F.R. § 1004.60(b)). The provider once again has thirty days to submit additional information, this time to OIG. 42 C.F.R. § 1004.60(b)(2). OIG then reviews the determi-

[4] When the PRO finds a "substantial violation in a substantial number of cases," the regulations outline an additional procedure, which includes sending a "written *initial* notice of the identification of a violation." 42 C.F.R. § 1004.40(b) (emphasis added). That notice must indicate the proposed sanction and must give the provider twenty days to submit additional information or request a meeting to discuss the determination. 42 C.F.R. §§ 1004.40(b)(5) & (6). The notice might also include, at the PRO's discretion, a suggestion for corrective action. 42 C.F.R. § 1004.40(b)(4). The 1988 regulations did not provide for corrective action in the case of "gross and flagrant" violations. Pursuant to a 1992 amendment, 42 C.F.R. § 1004.50(b)(4) now directs the PRO to suggest corrective action, "if appropriate," for either a "substantial" or a "gross and flagrant" violation.

nation and recommended sanction (42 C.F.R. § 1004.90) and notifies both the provider and the public of its decision (42 C.F.R. § 1004.100). Finally, the regulations provide:

> The determination and notice of sanction provided for in this section constitute an "initial determination" and a "notice of initial determination" for purposes of the administrative appeals procedures specified in Part 498 of this title concerning determinations and appeals procedures for providers and suppliers.

42 C.F.R. § 1004.100(g).

Part 498 in turn sets out a procedure for administrative review. First, the provider may request reconsideration by HCFA. 42 C.F.R. § 498.22. He may then request a hearing before an administrative law judge (42 C.F.R. §§ 498.40-498.78), whose decision is subject to review by an Appeals Council (42 C.F.R. § 498.80-95). After completing the administrative review process, the provider may file a civil action in federal district court pursuant to 42 U.S.C. § 405(g). 42 U.S.C. § 1320c-5 (4); 42 C.F.R. § 498.103.

Between 1986 and 1991, CIMRO reviewed the medical services Assar provided to Medicare beneficiaries.[5] In August 1989, CIMRO found that Assar had committed a gross and flagrant violation[6] and as a result required him to obtain a second opinion before performing any non-emergency surgery. (Complaint at Count I

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[5] This factual summary derives from Assar's First Amended Complaint ("Complaint"). We adopt his version of the facts in considering defendants' motion to dismiss.

[6] The violation related to an elderly patient, whose death CIMRO's report attributed to inappropriate emergency room care. According to the report, Assar may have been at least partially responsible for that care. The report also includes several additional less serious violations. (Complaint Ex. 1 at 3).

¶¶ 7, 13). CIMRO, however, did not provide Assar with written notice as required by 42 C.F.R. § 1004.50 and did not submit a report to OIG as required by 42 C.F.R. § 1004.70. The latter failure, according to Assar, prevented the administrative review process from going forward.[7] He thus claims that CIMRO "constructively and effectively prevented him from appealing its decisions either through administrative review or judicial review." (Complaint at Count I ¶ 14). He also claims that CIMRO acted beyond its authority when it imposed "practice restrictions" (*id.* at Count I ¶ 12; *see supra* n.7) and that CIMRO published false and defamatory statements about him in violation of 42 U.S.C. § 1320c-9[8] and 42 C.F.R. §§ 476.107 & 476.139. (Complaint at Count I ¶ 10). Assar asserts that he "has exhausted all administrative appeal remedies by sending multiple re-

---

[7] The defendants assert that CIMRO did not follow these steps because Assar had agreed to participate in a corrective action plan (receiving the second surgical opinions) in order to avoid being excluded from the Medicare program. They claim that if Assar had not agreed to participate in the corrective action plan, the report and recommendation would have been sent to OIG and the administrative review process would thereby have been set into motion. Assar argues that the PRO had no authority to institute a corrective action plan because the 1988 regulation did not provide that option for "gross and flagrant" violations. Defendants respond that despite the absence of regulatory authorization, HCFA's policy was to allow corrective action plans for "gross and flagrant violations" even before the regulation was amended. (*See* Complaint Ex. 6 at 2). This dispute is irrelevant for purposes of defendants' motion to dismiss, as to which we must make all factual inferences in Assar's favor.

[8] 42 U.S.C. § 1320c-9(a) provides that "[a]ny data or information acquired by any [PRO] in the exercise of its duties and functions shall be held in confidence and shall not be disclosed to any person . . . ," with various enumerated exceptions related to the Act's purpose. Subpart (c) of the section provides that "any person violating the provisions of this section shall, upon conviction, be fined not more than $1,000, and imprisoned for not more than 6 months . . . ."

quests to CIMRO and its attorney as well as the Department of Health and Human Services, Health Care Financing Administration . . . requesting appeals, hearings, and reviews of the illegal PRO actions . . . which were subsequently denied . . . ." (*Id.* at Count I ¶ 15).

All parties agree that there was no final administrative decision here that would have been reviewable in federal district court under 42 U.S.C. § 405(g). Instead, Counts I and II of Assar's complaint purport to arise "under Part B of Title XI and Title XVIII as well as other parts of the Social Security Act" and do not assert any other basis for federal jurisdiction. (Complaint at Count I ¶ 1, Count II ¶ 1). Count III asserts a Fifth Amendment due process claim and cites 28 U.S.C. § 1331 as the basis for federal jurisdiction. All three counts seek compensatory and punitive damages.

## II. Counts I and II

The basis for the first two counts of Assar's complaint is not immediately apparent. The Social Security Act contains no provision expressly authorizing damages actions against PROs, and Assar's complaint does not cite any particular provision as giving rise to such an action. Be that as it may, the district court did not directly address the basis for Counts I and II, but focused only on Assar's Count III due process claim.[9] Assar did not contest the court's decision in a post-judgment motion and has addressed only the constitutional claim on appeal.[10]

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[9] After concluding that no remedy was available for the alleged due process violation, the district court stated, "there is no other basis for federal jurisdiction either alleged or available." *Assar v. Crescent Counties Found*, No. 92-2161, slip op. at 7 (C.D. Ill. Oct. 6, 1992).

[10] Assar's jurisdictional statement on appeal states, "[t]his case arises under the Constitution and, therefore, the District Court had jurisdiction under 28 U.S.C. § 1331." He does not articulate any theory under which the Social Security Act itself might give rise to a private damages action. Perhaps he means to do so when

Having failed to challenge the dismissal of Counts I and II on appeal, Assar has apparently acquiesced in the district court's implicit decision that these counts stated no viable cause of action.

## III. Count III

Assar attempts to rest Count III on the Fifth Amendment, relying on the theory first articulated in *Bivens v. Six Unknown Named Agents of the Federal Bureau of Narcotics,* 403 U.S. 388 (1971). There, the Supreme Court held that individuals whose Fourth Amendment rights had been violated by federal officers could sue for money damages in federal court. The Court found "no special factors counselling hesitation in the absence of affirmative action by Congress" (*id.* at 396) and noted the absence of any "explicit congressional declaration that persons injured by a federal officer's violation of the Fourth Amendment may not recover money damages from the agents, but must instead be remitted to another remedy, equally effective in the view of Congress" (*id.* at 397). *See also Davis v. Passman,* 442 U.S. 228, 246-47 (1979).

In *Bush v. Lucas,* 462 U.S. 367, 378 (1983), the Court summarized the considerations that are relevant in determining whether damages are available for constitutional violations by federal actors:

> When Congress provides an alternative remedy, it may of course, indicate its intent, by statutory language, by clear legislative history, or perhaps even by the statutory remedy itself, that the courts' power should not be exercised. In the absence of such a congressional directive, the federal courts must make

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ne cites 42 U.S.C. § 1320c-6 (*see* Assar brief at 16-20), but he has failed to explain how this provision—which appears to do nothing more than bar or limit civil or criminal liability of various individuals or entities under certain circumstances—would *give rise to* a federal cause of action.

> the kind of remedial determination that is appropriate for a common-law tribunal, paying particular heed, however, to any special factors counseling hesitation before authorizing a new kind of federal litigation.

In *Bush*, a federal civil servant who alleged that he had been wrongfully discharged in retaliation for exercising his first amendment rights sued for damages. Although the Court noted that Congress had neither expressly precluded a damages remedy nor provided an equally effective alternative (*id.*), it nonetheless found "special factors counselling hesitation." The Court concluded that "special factors" related to "the question of who should decide whether such a remedy should be provided" (*id.* at 380) and, in light of the administrative review process that was already in place, explained:

> The question is not what remedy the court should provide for a wrong that would otherwise go unredressed. It is whether an elaborate remedial system that has been constructed step by step, with careful attention to conflicting policy considerations, should be augmented by the creation of a new judicial remedy for the constitutional violation at issue. That question obviously cannot be answered simply by noting that existing remedies do not provide complete relief for the plaintiff.

*Id.* at 388. Finding ultimately that "Congress is in a better position to decide whether or not the public interest would be served by creating" a damages remedy, the Court declined to do so. *Id.* at 390.

In *Schweiker v. Chilicky*, 487 U.S. 412 (1988), the Court explored *Bivens* and its progeny in a context very similar to our own. Plaintiffs who had been denied social security benefits sought damages for alleged due process violations. Summarizing its own post-*Bivens* case law, the Court explained:

> [T]he concept of "special factors counselling hesitation in the absence of affirmative action by Congress" has proved to include an appropriate judicial deference to indications that congressional inaction has not been inadvertent. When the design of a Government program suggests that Congress has provided what it considers adequate remedial mechanisms for constitutional violations that may occur in the course of its administration, we have not created additional *Bivens* remedies.

*Id.* at 423. The Court noted that the Social Security Act provided for several levels of administrative review and for subsequent judicial review, which would include review of constitutional claims, under 42 U.S.C. §§ 405 (g) & 421(d). Although that process did not offer complete relief—damages for constitutional violations were unavailable—the Court found that Congress "has not failed to provide meaningful safeguards or remedies for the rights of persons situated as respondents were." *Id.* at 425. It further reasoned that "[i]n light of the comprehensive statutory scheme[] involved, the harm resulting from the alleged constitutional violation can[not] be separated from the harm resulting from the denial of the statutory right." *Id.* at 428. The Court thus concluded:

> Whether or not we believe that its response was the best response, Congress is the body charged with making the inevitable compromises required in the design of a massive and complex welfare benefits program. Congress has discharged that responsibility to the extent that it affects the case before us, and we see no legal basis that would allow us to revise its decision.

*Id.* at 429 (citations omitted).

Relying on *Chilicky*, the Tenth Circuit in *Hilst v. Bowen*, 874 F.2d 725 (10th Cir. 1989) (per curiam), dismissed a complaint very similar to Assar's. In that

case, a physician sought damages for due process violations that allegedly had occurred when he was suspended from the Medicare program for falsifying claim forms and providing unnecessary services. Although administrative review ultimately cleared him of those charges, Hilst claimed that he should have been reinstated in the program during the pendency of his appeal. The court did not allow his *Bivens* action, reasoning:

> In this case, a comprehensive remedy is provided to physicians when their right to participate in the Medicare program is suspended. As in *Chilicky,* this remedy includes an elaborate administrative hearing, and administrative and judicial review. Although this remedial framework does not provide Hilst with consequential damages arising from defendant's unconstitutional conduct, the Court in *Chilicky* clearly indicated that this lack does not entitle a plaintiff to maintain a *Bivens* action so long as the remedy, although incomplete, is adequate and the safeguards are meaningful. We believe that the reasoning of *Chilicky* is applicable here and precludes Hilst from pursuing a *Bivens* action.

*Id.* at 727-28 (citations omitted).

As was true in *Chilicky* and *Hilst,* Congress has created a comprehensive scheme by which physicians can obtain review of PRO decisions affecting their participation in the Medicare program. As in those cases, the harm resulting from the alleged constitutional violation is indistinguishable from the harm resulting from the denial of the statutory right. The fact that the particular remedy Assar seeks is unavailable under the existing framework does not justify creation of a *Bivens* remedy. *See Feit v. Ward,* 886 F.2d 848, 854 (7th Cir. 1989).

Assar argues that his case is distinguishable from *Chilicky* and *Hilst* because CIMRO prevented his participation in the remedial scheme that was available by failing

to submit a report and recommendation to OIG.[11] But our decision today addresses only the availability of a *damages* remedy, which is the sole relief that Assar has requested. He has not sought to compel CIMRO's compliance with the regulations.[12]

## IV. Conclusion

No *Bivens* remedy is available to Assar in light of the comprehensive remedial scheme set forth in the statute and regulations. The district court's dismissal of Assar's complaint is AFFIRMED.

A true Copy:

Teste:

.....

Clerk of the United States Court of
Appeals for the Seventh Circuit

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[11] As already noted, the defendants dispute Assar's factual assertions (*see* n.7), but that factual dispute is irrelevant for our purposes.

[12] He might, for example, have sought relief under 28 U.S.C. § 1361, the federal mandamus statute, which provides:

> The district courts shall have original jurisdiction of any action in the nature of mandamus to compel an officer or employee of the United States or any agency thereof to perform a duty owed to the plaintiff.

Although we are not now asked to decide whether such relief is available in these circumstances, we did hold in *Burnett v. Bowen*, 830 F.2d 731, 738 (7th Cir. 1987), that "Congress intended to preserve mandamus jurisdiction for claims that are procedural in nature under the Social Security Act." Assar seems to acknowledge the availability of mandamus relief when he states that "28 U.S.C. § 1361 is not the exclusive or mandatory avenue by which Plaintiff must pursue claims against the PRO." (Assar Brief at 13).

## APPENDIX B

[Filed Oct. 6, 1992]

IN THE UNITED STATES DISTRICT COURT
FOR THE CENTRAL DISTRICT OF ILLINOIS

---

Case No. 92-2161

ABBAS ASSAR,

*Plaintiff,*

vs.

CRESCENT COUNTIES FOUNDATION FOR MEDICAL CARE and CENTRAL ILLINOIS MEDICAL REVIEW ORGANIZATION,

*Defendants.*

---

### ORDER

The plaintiff, Dr. Abbas Assar, seeks compensatory and punitive damages for common law torts and for denial of due process under the Fifth Amendment. The defendants, Crescent Counties Foundation for Medical Care ("CCFMC") and Central Illinois Medical Review Organization ("CIMRO"), have each moved to dismiss the plaintiff's claims under Fed. R. Civ. P. 12. For the reasons set forth below, the court grants the defendants' motions.

### FACTS

The plaintiff is a licensed physician practicing medicine and residing in Illinois. The defendants are "utilization and quality control peer review organizations (PROs)" created pursuant to the Social Security Act, at 42 U.S.C. § 1320 (1991).[1] A PRO contracts with the Department of Health and Human Services to review

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[1] All references in this order to the United States Code and Code of Federal Regulations are to the 1991 editions of these publications.

the provision of medical care to Medicare beneficiaries by physicians and hospitals participating in the Medicare program. Under 42 U.S.C. § 1320c-1, a PRO is to perform reviews which are based on objective criteria and which are designed to assure that services to beneficiaries under the Act:

> (1) will be provided economically and only when, and to the extent, medically necessary;
>
> (2) will be of a quality which meets professionally recognized standards of health care; and
>
> (3) will be supported by evidence of medical necessity and quality in such form and fashion and at such time as may reasonably be required by a reviewing peer review organization in the exercise of its duties and responsibilities.

If a PRO determines that a health care provider may have failed to comply with any of these requirements, then the PRO must provide "reasonable notice and opportunity for discussion with the practitioner or person concerned." 42 U.S.C. § 1320c-5(b)(1).[2]

Once the PRO determines that the practitioner has either failed in a substantial number of cases to comply with any obligation under the Act or "grossly and flagrantly violated any such obligation in one or more instances," then the PRO "shall submit a report and recommendations to the Secretary." *Id.*; 42 C.F.R. § 1004.30 (c). If the PRO determines that the violation is one that is gross and flagrant, then under 42 C.F.R. §§ 1004.40(a), 1004.50, the PRO must give written

---

[2] For initial determinations made by a PRO after Nov. 5, 1990, the Act further states that a PRO should also provide, "if appropriate, . . . a reasonable opportunity to enter into and complete a corrective action plan." *Id.* (as amended by Pub. L. 101-508, §§ 4205(a)(1)((A), 4205(a)(2) (1990)). However, the alleged initial determination in this case was made in August, 1989, prior to the effective date of this amendment.

notice to the practitioner or other person which states the following information:

> (1) The determination of a violation.
>
> (2) The obligation violated.
>
> (3) The basis for the determination.
>
> (4) The sanction the PRO will recommend to the OIG.
>
> (5) The right of the practitioner or other person to submit to the PRO within 30 days of receipt of the notice, additional information or a written request for a meeting with the PRO to review and discuss the determination, or both. . . .
>
> (6) A copy of the material used by the PRO in arriving at its determination.

The PRO then must reconsider its determination and either affirm, modify, or reverse its earlier determination, and give the practitioner written notice of any action that it takes based upon any additional information received. *Id.* If the issue is not resolved by the PRO at this stage, then the PRO must submit a report and recommendation to the Secretary (through the Office of the Inspector General, or "OIG"). 42 U.S.C. § 1320c-5(b)(1). If the OIG affirms the PRO's recommendation, then the OIG may impose sanctions, such as excluding the practitioner from eligibility to provide services under Medicare.[3] The Act then provides for several levels of appeal. It first provides for a hearing with an administrative law judge, then review of that decision by an Appeals Coun-

---

[3] For initial determinations by a PRO prior to Nov. 5, 1990, in order to impose a sanction, the OIG must find that "such practitioner or other person . . . has demonstrated an unwillingness or a lack of ability substantially to comply with such obligations." 42 U.S.C. § 1320c-5(b)(1) (as amended by Pub. L. 101-508, §§ 4205(a)(1)(B), 4205(a)(2) (1990)). This amendment postdates the alleged initial determination in the case at hand.

cil, and finally judicial review in a civil action, if appropriate.

The defendant CCFMC contracted with the federal government to perform reviews of medical services pursuant to the Act. The defendant CIMRO subcontracted with CCFMC.

In early August, 1989, CIMRO performed a review of the plaintiff's provision of medical care to a Medicare patient and allegedly issued a gross and flagrant quality of care deficiency against the plaintiff. On September 6, 1989, CIMRO allegedly imposed practice restrictions and limitations against Dr. Assar limiting his rights and abilities to care for Medicare patients under the federal Medicare program. The plaintiff first claims that these restrictions have effectively excluded him from participation in the Medicare program and that the imposition of these "sanctions" exceeded the authority of the defendants. The plaintiff then claims that, upon the August, 1989 finding of a "gross and flagrant" deficiency, the defendants were required to submit a report and recommendation to the OIG which would initiate administrative review of the defendants' actions. Because the defendants have allegedly failed to submit a report to the OIG, the plaintiff asserts that he is essentially caught in a "Catch-22." He claims he is unable to pursue an administrative appeal due to the defendants' unlawful inaction, and yet he cannot obtain judicial review of this unlawful inaction because of his failue to exhaust administrative remedies.

In Counts I and II of his amended complaint, Dr. Assar alleges that CIMRO and CCFMC, through CIMRO, negligently and maliciously failed to comply with review procedures and guidelines, reporting requirements, and nondisclosure rules, and furthermore that CIMRO published defamatory statements, acted manifestly and palpably beyond its authority, acted without due care, and acted in retaliation for previous disputes with CIMRO. In Count III, Dr. Assar claims that, by

imposing sanctions outside their authority and preventing administrative review of these actions by failing to submit a report to the OIG, the defendants' actions constituted an intentional denial of Plaintiff's Fifth Amendment right to due process.

## ANALYSIS

Subject matter jurisdiction must be pled and established by the party invoking it. Fed. R. Civ. P. 8(a). The plaintiff's amended complaint states that the action "arises under the Fifth Amendment of the United States Constitution" and "under Part B of Title XI and Title XVIII as well as other parts of the Social Security Act." For the constitutional claim asserted in Count III, the plaintiff pleads federal question jurisdiction under 28 U.S.C. § 1331. In the plaintiff's Brief in Reply to Defendants Motion to Dismiss, at 4-5, the plaintiff cites *Bivens v. Six Unknown Federal Narcotics Agents,* 403 U.S. 388 (1971), as the "controlling case" regarding his constitutional claim.

The Supreme Court decision in *Bivens* generally stands for the proposition that a private cause of action for damages may exist in federal court for victims of constitutional violations by federal officers acting under color of their authority. In subsequent decisions, a *Bivens* action has been permitted under 28 U.S.C. § 1331 where there are "no 'special factors counselling hesitation in the absence of affirmative action by Congress,' no explicit statutory prohibition against the relief sought, and no exclusive statutory alternative remedy." *Schweiker v. Chilicky,* 487 U.S. 412, 421 (1987) (citing *Davis v. Passman,* 442 U.S. 228, 246-47 (1979), and *Carlson v. Green,* 446 U.S. 14, 18-20 (1980)). Whether this Court has jurisdiction to hear Dr. Assar's claims depends initially on whether Congress has precluded federal question jurisdiction over a *Bivens* action for constitutional violations of the Social Security Act.

In 42 U.S.C. § 1395ii, Congress makes 42 U.S.C. § 405(h) of the Social Security Act applicable to the Medicare program. Section 405(h) provides that:

> The findings and decisions of the Secretary after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Secretary shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the Secretary, or any officer or employee thereof shall be brought under section 1331 or 1346 of Title 28 to recover on any claim arising under this subchapter.

Under *Weinberger v. Salfi*, 422 U.S. 749 (1975), this provision was interpreted to bar federal question jurisdiction of a suit challenging the constitutionality of a provision in the Act, where the plaintiffs sought declaratory and injunctive relief as well as damages equivalent to the Social Security benefits denied by the Secretary based on the challenged provision. The plaintiffs argued that their action arose under the Constitution and not under the Social Security Act. *Id.* at 760. The Court held that the claim arose under *both* the Constitution and the Social Security Act: "For not only is it Social Security benefits which appellees seek to recover, but it is the Social Security Act which provides both the standing and the substantive basis for the presentation of their constitutional contentions." *Id.* at 760-61. However, the impact of the decision in *Weinberger* on the question of whether § 405(h) precludes a *Bivens* remedy is unclear. The Supreme Court noted in *Chilicky*, 487 U.S. at 429 n.3 (citing *Weinberger*, 422 U.S. at 756-62; *Heckler v. Ringer*, 466 U.S. 602, 614-16, 620-26 (1984); *Bowen v. Michigan Academy of Family Physicians*, 476 U.S. 667, 679 (1986)), in an action where the plaintiffs sought consequential damages for hardships resulting from an allegedly unconstitutional denial of Social Security

benefits, that "the exact scope of the third sentence's restriction [in § 405(h)] on federal-question jurisdiction is not free from doubt; because we hold on other grounds that a *Bivens* remedy is precluded in this case, we need not decide whether § 405(h) would have the same effect." The Supreme Court has thus reserved the question of whether a plaintiff may bring a *Bivens* action in federal court for a constitutional claim based on violations of the Social Security Act.

In *Bodimetric Health Servs., Inc. v. Aetna Life & Casualty*, 903 F.2d 480, 488-490 (7th Cir. 1990), where the plaintiff sought damages for common law torts allegedly committed by a fiscal intermediary under the Medicare program, the Seventh Circuit interpreted the scope of the jurisdictional restriction in § 405(h), but only to the extent that it found § 405(h) precluded a federal district court from review of a claim based on diversity jurisdiction. The court noted that:

> A party cannot avoid the Medicare Act's jurisdictional bar simply by styling its attack as a claim for collateral damages instead of a challenge to the underlying denial of benefits. If litigants who have been denied benefits could routinely obtain judicial review of these decisions by recharacterizing their claims under state and federal causes of action, the Medicare Act's goal of limited judicial review for a substantial number of claims would be severely undermined.

*Id.* at 487 (citations omitted). While the court was not presented with a plaintiff alleging a constitutional claim, the court's hesitancy to find jurisdiction in cases involving Medicare argues against this court asserting jurisdiction over Dr. Assar's claims.

Regardless of whether § 405(h) precludes a *Bivens* remedy, this court holds that a *Bivens* remedy is not available for alleged due process violations in the exclu-

sion of a Medicare provider from the Medicare program. Under *Northlake Community Hospital v. United States*, 654 F.2d 1234, 1241-3 (7th Cir. 1981), the Seventh Circuit determined that a Medicare provider has a constitutionally-protected property right in the expectation of continuing participation in the Medicare program. Thus, the primary issue before this court is whether a *Bivens* remedy is appropriate for alleged due process violations in the exclusion of a Medicare provider from the Medicare program.

In *Bivens*, the court fashioned a remedy for the plaintiff where there were "no special factors counselling hesitation in the absence of affirmative action by Congress," and "no explicit congressional declaration" that money damages could not be awarded. *Bivens*, 403 U.S. at 396-97. Recently, in addressing the appropriateness of a *Bivens* action for alleged due process violations in the denial of social security disability benefits, the Court stated that:

> In sum, the concept of 'special factors counselling hesitation, in the absence of affirmative action by Congress' has proved to include an appropriate judicial deference to indications that congressional inaction has not been inadvertent. When the design of a Government program suggests that Congress has provided for what it considers adequate remedial mechanisms for constitutional violations that may occur in the course of its administration, we have not created additional *Bivens* remedies.

*Chilicky*, 487 U.S. at 423. The Court held that a *Bivens* remedy was unavailable due to the "comprehensive statutory scheme" created by Congress to "address[] the problems created by state agencies' wrongful termination of disability benefits." *Id.* at 428-29. The case before this court is virtually indistinguishable from *Chilicky*. Thus, as the design of the Medicare program within the Social Security Act suggests that Congress has provided ade-

quate remedial mechanisms for constitutional violations in the administration of the program, this court holds that a cause of action under *Bivens* for just such constitutional violations is not available.

Just as the Social Security Act "makes no provision for remedies in money damages against officials responsible for unconstitutional conduct that leads to the wrongful denial of benefits," *id.* at 424, the Medicare program within the Social Security Act also makes no provision for remedies in money damages against officials responsible for unconstitutional conduct that leads to the wrongful exclusion of a practitioner from participation in the Medicare program. Once such a practitioner's participation in the Medicare program is fully restored through the administrative process, that practitioner lacks standing for an action based on the Constitution under the statute's administrative review provisions. As in *Chilicky*, while the "creation of a *Bivens* remedy would obviously offer the prospect of relief for injuries that must now go unredressed," Congress "has not failed to provide meaningful safeguards or remedies for the rights of persons wrongfully deprived of participation in the Medicare program. *Id.* at 425.[4] The Social Security Act includes detailed statutory mandates providing for several levels of administrative review of the actions of PROs and the sanctioning of a Medicare provider. Where a PRO or any other federal official obstructs this process or fails to comply with these statutory requirements, then a federal district court may issue a mandamus to compel compliance with these laws under 28 U.S.C. § 1361. "In

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[4] *See also Feit v. Ward*, 886 F.2d 848, 854 (7th Cir. 1989) ("Simply stated, the Supreme Court's rationale in *Chilicky*, particularly the Court's analysis of *Bush v. Lucas*, makes clear that under the 'special factors' analysis, determining whether the *particular* remedies available to the plaintiff claiming a violation of his constitutional rights are meaningful and adequate is unnecessary." (emphasis in original)).

light of the comprehensive statutory schemes involved, the harm resulting from the alleged constitutional violation [cannot] be separated from the harm resulting from the denial of the statutory right." *Id.* at 428.

As a *Bivens* remedy is not available to the plaintiff as a matter of law, and there is no other basis for federal jurisdiction either alleged or available, this case must be dismissed for lack of subject matter jurisdiction under Fed. R. Civ. P. 12(b)(1).

IT IS THEREFORE ORDERED that the defendant's motion to dismiss for lack of jurisdiction (docket #25-2) is GRANTED.

IT IS FURTHER ORDERED that all other pending motions (docket #5-1, #8-1, #12-1, #16-1, #18-1, #25-1) are DENIED as moot.

ENTER THIS 6th day of October, 1992.

/s/ Harold A. Baker
HAROLD A. BAKER
United States District Judge

## APPENDIX C

UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT
Chicago, Illinois 60604

March 9, 1994

*Before* HONORABLE WILLIAM J. BAUER,
Circuit Judge
HONORABLE MICHAEL S. KANNE,
Circuit Judge
HONORABLE ILANA DIAMOND ROVNER,
Circuit Judge

---

No. 92-3678

ABBAS ASSAR, M.D.,
*Plaintiff-Appellant,*
v.

CRESCENT COUNTIES FOUNDATION FOR MEDICAL CARE and CENTRAL ILLINOIS MEDICAL REVIEW ORGANIZATION (CIMRO),
*Defendants-Appellees.*

---

Appeal from the United States District Court
for the Central District of Illinois, Danville Division
No. 92 C 2161—Harold A. Baker, Judge

---

ORDER

On consideration of the petition for rehearing filed by plaintiff-appellant on January 11, 1994, all of the judges on the original panel having voted to deny the same,

IT IS HEREBY ORDERED that the aforesaid petition for rehearing be, and the same is hereby, DENIED.

## APPENDIX D

## REGULATIONS INVOLVED

Subpart C—PRO Responsibilities

§ 1004.50 Action on determination of a violation.

(a) *Written notice.* The PRO must give written notice to the practitioner or other person if it determines that—

(1) A substantial violation has occurred in a substantial number of cases; or

(2) A violation is gross and flagrant in one or more cases.

(b) *Contents.* The notice must contain the following information:

(1) The determination of a violation.

(2) The obligation violated.

(3) The basis for the determination.

(4) The sanctions the PRO will recommend to the OIG.

(5) The right of the practitioner or other person to submit to the PRO within 30 days of receipt of the notice, additional information or a written request for a meeting with the PRO to review and discuss the determination, or both. The date of receipt is presumed to be five days after the date on the notice, unless there is a reasonable showing to the contrary.

(6) A copy of the material used by the PRO in arriving at its determination.

(c) *Review of PRO determination.*

(1) The PRO may, on the basis of additional information received, affirm, modify, or reverse its determination.

(2) The PRO must give written notice to the practitioner or other person, of any action it takes as a result of the additional information received, as specified in § 1004.60.

§ 1004.70 PRO report to OIG.

(a) *Manner of reporting.* If the PRO determines that a substantial violation has occurred in a substantial number of cases or that a gross and flagrant violation has occurred, it must submit a report and recommendation to the OIG at the original office with jurisdiction.

(b) *Content of report.* The PRO report must include the following information—

(1) Identification of the practitioner or other persons and when applicable, the name of the director, administrator, or owner of the entity involved.

(2) The type of health care services involved;

(3) A description of each failure to comply with an obligation, including specific dates, places, circumstances, and any other relevant facts;

(4) Pertinent documentary evidence;

(5) Copies of written correspondence and written summaries or oral exchanges with the practitioner or other person regarding the violation;

(6) The PRO's determination that an obligation under section 1156(a) of the Act has been violated and that the violation is substantial and has occurred in a substantial number of cases or is gross and flagrant;

(7) The professional qualifications of the PRO's reviewers' and

(8) The PRO's sanction recommendation.

(c) *PRO Recommendation.* The PRO must specify in its report—

(1) The sanction recommended;

(2) The amount of the monetary penalty recommended, if applicable;

(3) The period of exclusion recommended, if applicable; and

(4) A recommendation as to whether the practitioner or other person is unable or unwilling substantially to comply with the obligation that was violated.

## Subpart D—OIG Responsibilities

### § 1004.90 Acknowledgement and review of report.

(a) *Acknowledgement.* The OIG will inform the PRO of the date it received the PRO's report and recommendation.

(b) *Review.* The OIG will review the PRO report and recommendation to determine whether—

(1) The PRO is following its procedures;

(2) A violation has occurred; and

(3) The practitioner or other person has demonstrated an unwillingness or lack of ability substantially to comply with an obligation.

(c) *Rejection of the PRO recommendation.* If the OIG decides that a sanction is not warranted, it will notify the PRO that recommended the sanction and the affected practitioner or other person that the recommendation is rejected.

(d) *Decision of sanction.* If the OIG decides that a violation of obligations has occurred, it will determine the appropriate sanction by considering—

(1) The recommendation of the PRO;

(2) The type of offense;

(3) The severity of the offense;

(4) The previous sanction record of the practitioner or other person;

(5) The availability of alternative sources of services in the community;

(6) Any prior problems the Medicare carrier or intermediary has had with the practitioner or other person;

(7) Whether the practitioner or other person is unable or unwilling to comply substantially with the obligations; and

(8) Any other matters relevant to the particular case.

(e) *Exclusion sanction.* If the PRO submits a recommendation for exclusion to the OIG, and a determination is not made by the 120th day after actual receipt by the OIG, the exclusion sanction recommended will become effective and the OIG will provide notice in accordance with § 1004.100(f).

(f) *Monetary penalty.* If the PRO recommendation is to assess a monetary penalty, the 120-day provision does not apply and the OIG will provide notice in accordance with § 1004.100(a) through (c).

Supreme Court, U.S.
FILED
JUL 6 1994
OFFICE OF THE CLERK

No. 93-1944

# In the Supreme Court of the United States

OCTOBER TERM, 1994

ABBAS ASSAR, M.D.,
*Petitioner,*

v.

CRESCENT COUNTIES FOUNDATION FOR MEDICAL CARE
and
CENTRAL ILLINOIS MEDICAL REVIEW ORGANIZATION,
*Respondents.*

**On Petition for a Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit**

## BRIEF FOR CRESCENT COUNTIES FOUNDATION FOR MEDICAL CARE AND CENTRAL ILLINOIS MEDICAL REVIEW ORGANIZATION IN OPPOSITION

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BEST AVAILABLE COPY

## QUESTION PRESENTED

Whether this Court should review the Seventh Circuit's determination that Petitioner's *Bivens* claim for money damages for alleged constitutional violations arising from the administration of the peer review portion of the Medicare program is precluded by the existence of a comprehensive statutory and regulatory remedial mechanism, where the court of appeals carefully analyzed Petitioner's claim in light of *Schweiker* v. *Chilicky*, 487 U.S. 412 (1988), and related cases, and where its ruling is consistent with the decisions of other courts of appeals.

## RULE 29.1 STATEMENT

Crescent Counties Foundation for Medical Care is an Illinois not-for-profit corporation. It has no parent company or non-wholly-owned subsidiaries.

Central Illinois Medical Review Organization is an Illinois not-for-profit corporation. It has no parent company or non-wholly-owned subsidiaries.

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42 C.F.R. Part 1005 (1993) . . . . . 5

42 C.F.R. § 498.80 . . . . . 5

42 C.F.R. § 1004.1(b) . . . . . 4

42 C.F.R. §§ 1004.40 to 1004.80 . . . . . 3

42 C.F.R. § 1004.40(b)(4) . . . . . 4, 7

42 C.F.R. § 1004.50 . . . . . 5

42 C.F.R. §§ 1004.60, 1004.70 . . . . . 4, 5

42 C.F.R. § 1004.60(b)(2) . . . . . 5

42 C.F.R. § 1004.90(b) . . . . . 5

42 C.F.R. § 1004.90(d) . . . . . 5

42 C.F.R. § 1004.90(e) . . . . . 5

42 C.F.R. § 1004.130(a)(1) . . . . . 5

## BRIEF FOR CRESCENT COUNTIES FOUNDATION FOR MEDICAL CARE AND CENTRAL ILLINOIS MEDICAL REVIEW ORGANIZATION IN OPPOSITION

Respondents Crescent Counties Foundation for Medical Care ("CCFMC") and Central Illinois Medical Review Organization ("CIMRO") submit this brief in opposition to the petition for a writ of certiorari.

### JURISDICTION

The judgment of the court of appeals was entered on December 29, 1993. The court of appeals denied a petition for rehearing on March 9, 1994. The petition for a writ of certiorari was filed on June 6, 1994. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

### OPINION BELOW

The opinion of the court of appeals (Pet. App. 1a-11a) is reported at 13 F.3d 215. The order of the district court (Pet. App. 12a-21a) is unreported.

### STATEMENT

Petitioner sought to bring a *Bivens* claim for money damages for alleged constitutional violations resulting from the Respondents' administration of the peer review portion of the Medicare program. The Seventh Circuit affirmed the dismissal of this claim, concluding that under *Schweiker* v. *Chilicky*, 487 U.S. 412 (1988), and related cases, Congress had denied Petitioner a *Bivens* remedy by creating a comprehensive mechanism to redress injuries in the peer review system. In reaching this conclusion, the court of appeals applied well-established precedent to circumstances that are virtually indistinguishable from what this Court reviewed in *Chilicky*. The Seventh Circuit's opinion is consistent with the

decisions of both this Court and the lower courts. Accordingly, the petition for a writ of certiorari should be denied.

### A. Peer Review Organizations and the Medicare Review Scheme

Under the Medicare statutory scheme, peer review organizations ("PROs") perform several functions critical to "the effective, efficient, and economical delivery of health care services." 42 U.S.C. § 1395y(g).[1] A "utilization and quality control peer review organization" under 42 U.S.C. § 1320c *et seq.* consists of a representative group of physicians with different specialties from a given locality. 42 U.S.C. § 1320c-1. One PRO from each state contracts with the Health Care Financing Administration ("HCFA") of the Department of Health and Human Services ("HHS"). In turn, this PRO can subcontract with other PROs so that the statutory objectives are fulfilled. 42 U.S.C. § 1320c-2(c)(1). CCFMC provides federal Medicare peer review services in Illinois pursuant to a contract with HHS. At all times relevant to this action, CIMRO was a PRO subcontractor to CCFMC.

PROs perform numerous functions within the Medicare scheme, see generally 42 U.S.C. § 1320c-3 (defining the functions of PROs); however, their central responsibilities are three-fold. First, PROs review a hospital's participation in the Medicare program to determine whether the hospital's services are medically necessary and allowable. 42 U.S.C. § 1320c-3(a)(1). Second, PROs review whether the amounts

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[1] Because Petitioner challenges conduct occurring in 1989, Respondents have cited versions of the statutory provisions and regulations governing PROs that were current in 1989. The most relevant of these statutes and regulations are reprinted in Respondents' Appendix.

charged by individual physicians should be paid. 42 U.S.C § 1320c-3(a)(2). Finally, PROs play a role in ensuring that the physicians who participate in the Medicare program live up to their statutory duty that services:

> (1) will be provided economically and only when, and to the extent, medically necessary;
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> (2) will be of a quality which meets professionally recognized standards of health care; and
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> (3) will be supported by evidence of medical necessity and quality in such form and fashion and at such time as may reasonably be required by a reviewing peer review organization in the exercise of its duties and responsibilities.

42 U.S.C. § 1320c-5(a)(1)-(3).

It is this last function which is most directly relevant to this petition. Under the statute and its accompanying regulations, a PRO is empowered to recommend that a physician be sanctioned for violating the obligations to provide appropriate care to Medicare beneficiaries. 42 U.S.C. § 1320c-5(b)(1); 42 C.F.R. §§ 1004.40 to 1004.80. At the times relevant to this case, the statutes and regulations set up a multi-step process through which sanctions were imposed, involving the PRO, the Office of the Inspector General ("OIG") of HHS, agency administrative law judges and appeals panels, and the federal courts.

Once it has identified a violation of the Medicare duties and has identified the violator, a PRO is required, as the initial phase in the sanction process, to "determine the nature of the violation." 42 C.F.R. § 1004.40. If it determines that "a substantial violation in a substantial number of cases" has occurred, the PRO may recommend to the physician, in appropriate circumstances and at its discretion, "a suggested

method for correcting the situation and a time period for corrective action." 42 C.F.R. § 1004.40(b)(4). For "gross and flagrant" violations, 42 C.F.R. § 1004.1(b), the policy of HCFA at the time was also to encourage PROs and physicians to undertake corrective action in those circumstances where there was discovered a single gross and flagrant violation. See R. 24, First Amended Complaint (hereinafter "1st Am. Compl."), Ex. 6 at 2-3.[2] Through these corrective actions, the physician could choose to avoid a sanction that could preclude altogether his or her participation in the Medicare program. See 42 C.F.R. §§ 1004.60, 1004.70.[3]

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[2] In a letter to Petitioner's counsel dated December 9, 1991, Sina Ann Mercado of HCFA's Division of Health Standards and Quality described the agency's policy regarding the initiation of the sanction process when the PRO determined that a physician had committed a single "gross and flagrant" violation:

> On September 1, 1988 the PRO requested a contract modification to provide discretion in the initiation of the sanction process for single confirmed gross and flagrant issues as provided for in the Third Scope of Work (attachment A). Approval by HCFA was granted for this request on October 20, 1988. On January 21, 1989, Dr. Assar's case was confirmed as gross and flagrant at the second level of review. The Quality Peer Review Committee (QPRC) upheld the gross and flagrant designation and assigned a CAP [Corrective Action Plan] on August 8, 1989.

1st Am. Compl. Ex. 6 at 2-3.

[3] In 1990, section 1320c-5(b)(1) was amended to direct that a PRO should also provide to the practitioner, "if appropriate, . . . a reasonable opportunity to enter into and complete a corrective action plan." 42 U.S.C. § 1320c-5(b)(1) (as amended by Pub. L.

If the physician chooses not to undergo or complete the corrective action that is recommended, then additional sanction proceedings under the Medicare scheme can be triggered, including several levels of appeal. See, *e.g.*, 42 C.F.R. §§ 1004.60, 1004.70 (PRO recommendation of sanction to OIG); 42 U.S.C. § 1320c-5(b)(1); 42 C.F.R. § 1004.90(b) (OIG determination); 42 C.F.R. § 1004.90(d) (guidelines for imposition of sanction by OIG); 42 C.F.R. § 1004.90(e) (timeframe for exclusion sanction). An extensive appeals process is available from the OIG's determination. See, *e.g.*, 42 C.F.R. § 1004.130(a)(1) (ALJ); 42 C.F.R. § 498.80 (Appeals Council).[4] Under 42 U.S.C. § 1320c-5(b)(4), recourse to the federal courts under 42 U.S.C. § 405(g) is also available after the department takes its final action.

At each step in the process, the physician has the opportunity to be heard. He or she can decline to participate in a corrective action plan and instead opt for the additional steps in the sanction process. See, *e.g.*, 42 U.S.C. § 1320c-5(b)(1); 42 C.F.R. § 1004.50 (opportunity for discussion prior to submission of sanction recommendation to OIG); 42 C.F.R. § 1004.60(b)(2) (submission of additional information to OIG). And, of course, the appeals process provides for input from the physician as well.

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No. 101-508, § 4205(a)(1)(A), 104 Stat. 1388-112 (1990)). This amendment codifies the preexisting policy, followed here, of allowing PROs the opportunity to suggest corrective action to physicians in appropriate circumstances.

[4] In January 1992 these regulations were modified to provide additional procedural protections during the appeals process. See 42 C.F.R. Part 1005 (1993).

**B. Petitioner's Allegations**

Petitioner's complaint centered on this sanction process and the two PROs' conduct during it. The core of his allegations was that on or around August 8, 1989, CIMRO alleged that Petitioner provided substandard medical care to a Medicare patient and supposedly issued a "gross and flagrant" deficiency against him. 1st Am. Compl. at Ct. II, ¶ 7. He then asserted that on September 6, 1989, the two PROs allegedly sanctioned him by imposing "practice restrictions," which supposedly limited his "rights and abilities to care for Medicare patients under the federal Medicare program." *Ibid.* These alleged restrictions were a Corrective Action Plan ("CAP"). See *id.*, Exhs. 1, 3, 4, 6.

Petitioner contended that the PROs violated the sanction procedures by failing to forward a report of the "gross and flagrant" violation to plaintiff and to the OIG, 1st Am. Compl. at Ct. II, ¶¶ 8 & 9, and that the "review actions, penalties, [and] restrictions" were instituted with malice. *Id.* at ¶ 11. He also claimed that the PROs' alleged failure to follow the statute and regulations "constructively and effectively prevented him from appealing . . . through administrative review or judicial review." *Id.* at ¶ 15. In Count III of the First Amended Complaint, Petitioner charged that through this alleged conduct, CIMRO and CCFMC violated the Constitution.[5] He sought money

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[5] Petitioner's complaint included two additional counts against CCFMC and CIMRO seeking damages for alleged common law torts and violations of various federal statutes and regulations arising from the CAP. Although the precise substance of these counts is uncertain, see Pet. App. 6a, they include allegations resembling defamation and negligence. Petitioner does not challenge the district court's dismissal of these counts, see Pet.

damages under *Bivens* v. *Six Unknown Federal Narcotics Agents*, 403 U.S. 388 (1971), for these alleged constitutional violations.

Several additional aspects of Petitioner's complaint are relevant. First, Exhibit 1 of the First Amended Complaint showed several "substantial" violations of Petitioner's Medicare duties which the PRO also could address through "corrective action" pursuant to 42 C.F.R. § 1004.40(b)(4). In addition, as discussed above, HHS policy at the time relevant to this suit provided that the PROs could exercise "discretion in the initiation of the sanction process for single confirmed gross and flagrant issues" by suggesting corrective action. 1st Am. Compl., Ex. 6 at 2-3. Indeed, according to the complaint, HCFA granted a "contract modification" to allow the PROs to exercise their discretion. *Ibid.*

Second, Petitioner elected to participate in the Corrective Action Plan provided by CIMRO, and this plan has been closed. 1st Am. Compl., Ex. 6 at 4. By participating in this plan, Petitioner avoided more restrictive sanctions that could have precluded altogether his participation in the Medicare program.

Third, according to the complaint, Petitioner waited until August 1991 to contact HHS and "request[] an immediate review by HCFA to determine the appropriateness of the actions taken by the PRO." 1st Am. Compl., Ex. 4 at 11, & Ct. II, ¶ 16. This request was approximately two years after Petitioner's Corrective Action Plan was suggested by CIMRO and accepted by him.

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App. 6a-7a; consequently, they are not a subject of this petition.

### C. Proceedings Below

Petitioner filed his original complaint against CCFMC and CIMRO in the United States District Court for the Central District of Illinois on May 20, 1992, and he filed a First Amended Complaint on August 4, 1992. CCFMC and CIMRO moved to dismiss both complaints contending that Petitioner failed to state a claim because a *Bivens* action was barred by the Medicare program's comprehensive statutory and regulatory remedial mechanism. See *Schweiker* v. *Chilicky*, 487 U.S. 412 (1988). CCFMC and CIMRO also argued that they are protected by absolute immunity for their activities relating to the Medicare sanction process. See, *e.g.*, *Kwoun* v. *Southeast Missouri Prof. Standards Review Org.*, 811 F.2d 401 (8th Cir. 1987), cert. denied, 486 U.S. 1022 (1988).

On October 6, 1992, the district court issued an order dismissing Petitioner's complaint. Pet. App. 12a-21a. The court concluded that Petitioner's *Bivens* claims were barred by *Chilicky* and, since no other source for federal jurisdiction was cited apart from 28 U.S.C. § 1331, no subject matter jurisdiction existed over Petitioner's complaint. The district court did not address the immunity claim Respondents raised in their motions to dismiss.

Petitioner filed a notice of appeal to the United States Court of Appeals for the Seventh Circuit on October 29, 1992. In an opinion dated December 29, 1993, the Seventh Circuit affirmed the district court, concluding that the extensive remedial mechanism Congress established to resolve claims arising from the PRO program precluded Petitioner's claim for money damages. See Pet. App. 1a-11a.

The court of appeals began its analysis by explaining in detail both Petitioner's complaint and the multiple layers of review within both HHS and the federal courts that oversee

the work of the PROs. See Pet. App. 2a-6a. It then discussed the governing precedents, including *Chilicky* and the Tenth Circuit's opinion in *Hilst* v. *Bowen*, 874 F.2d 725, 727-28 (10th Cir. 1989), both of which found that a *Bivens* claim had been barred by the comprehensive remedial mechanisms of the Social Security system. The court concluded that in light of the remedies Congress had created, a *Bivens* claim for damages was not available. It noted that

> [a]s was true in *Chilicky* and *Hilst*, Congress has created a comprehensive scheme by which physicians can obtain review of PRO decisions affecting their participation in the Medicare program. As in those cases, the harm resulting from the alleged constitutional violation is indistinguishable from the harm resulting from the denial of the statutory right. The fact that the particular remedy Assar seeks is unavailable under the existing framework does not justify creation of a *Bivens* remedy.

Pet. App. 10a. The court of appeals also observed that although Petitioner claimed that this remedial scheme was not available to him, he also admitted that he could have sought mandamus to gain access to the scheme, if he believed that access was wrongfully denied him. Pet. App. 10a-11a.

## REASONS FOR DENYING THE WRIT

The question in this case is whether the court of appeals properly applied *Schweiker* v. *Chilicky*, 487 U.S. 412 (1988), and related cases when it concluded that the Social Security Act's comprehensive scheme to redress constitutional violations that occur during administration of the Medicare program precluded Petitioner's *Bivens* claim for money damages. Petitioner does not challenge that these comprehen-

sive remedies would prevent him from bringing a *Bivens* claim. Nor could he make this argument given the multiple layers of review Congress and HHS created to oversee the conduct of PROs.

Instead, his sole argument in support of certiorari is the assertion that he somehow could not gain access to these remedies and therefore he should have a right to sue Respondents for money damages. The problem with Petitioner's claim, however, is that it ignores reality. Both the district court and the court of appeals correctly determined that Petitioner affirmatively *could* have availed himself of the Act's comprehensive remedies if he had wished to do so. In fact, Petitioner enjoyed several avenues by which he could have sought relief. Also, contrary to Petitioner's assertions, the courts of appeals have been uniform in their application of *Chilicky* and related cases. Absolutely no division exists among the lower courts on issues relevant to this case.

## I. THE COURT OF APPEALS' DECISION IS WHOLLY CONSISTENT WITH THIS COURT'S PRECEDENTS

In *Bivens* v. *Six Unknown Federal Narcotics Agents*, 403 U.S. 388 (1971), this Court recognized that an action for money damages can exist against federal officials for violations of the Constitution. However, the Court also cautioned that in certain circumstances, "special factors" can "counsel[] hesitation" in implying a money remedy "in the absence of affirmative action by Congress." *Id.* at 396.

In *Bush* v. *Lucas*, 462 U.S. 367 (1983), the Court identified one of these "special factors" that can preclude a *Bivens* remedy. There the Court refused to allow a claim for money damages to go forward against federal officials who allegedly violated the First Amendment rights of a government employee. Because this claim arose "out of an employment

relationship that is governed by comprehensive procedural and substantive provisions giving meaningful remedies against the United States," the Court determined that it would be "inappropriate . . . to supplement that regulatory scheme with a new judicial remedy." *Id.* at 368. Instead, by setting up "an elaborate remedial system that has been constructed step by step, with careful attention to conflicting policy considerations," Congress had determined conclusively what remedies should exist for the aggrieved employee. *Id.* at 388. Because Congress, and not the Court, "is in a better position to decide whether or not the public interest would be served by creating" a remedy for money damages, the Court declined to allow a *Bivens* remedy. *Id.* at 390.

In *Schweiker* v. *Chilicky*, 487 U.S. 412 (1988), the Court applied these principles to bar the *Bivens* claim of Social Security recipients for money damages for, *inter alia*, "emotional distress and for loss of food, shelter and other necessities." *Id.* at 418-19. The Court concluded that a *Bivens* remedy had been barred by the comprehensive "administrative structure and procedures" of the Social Security system, *id.* at 424, through which "Congress . . . has addressed the problems created by state agencies' wrongful termination of disability benefits," *id.* at 429. This administrative scheme included several levels of agency review of benefits determinations, and, like the scheme governing PRO review, also provided for judicial review in the courts under 42 U.S.C. § 405(g). *Id.* at 424. The Court noted that "[i]n light of the comprehensive statutory schemes involved, the harm resulting from the alleged constitutional violation can in neither case be separated from the harm resulting from the denial of the statutory right." *Id.* at 428. Although the administrative scheme created by Congress did not provide a remedy for the plaintiffs' claims for money damages, the Court determined that this fact in itself was not

enough to infer the existence of a *Bivens* remedy. Despite the fact that the remedy it created was incomplete (*i.e.*, no money damages), "Congress . . . has not failed to provide meaningful safeguards or remedies for the rights of persons situated as respondents were." *Id.* at 425. The Court concluded by reasoning that

> Congress . . . has addressed the problems created by state agencies' wrongful termination of disability benefits. Whether or not we believe that its response was the best response, Congress is the body charged with making the inevitable compromises required in the design of a massive and complex welfare benefits program. Congress has discharged that responsibility to the extent that it affects the case before us, and we see no legal basis that would allow us to revise its decision.

*Id.* at 429 (citation omitted).[6]

The court of appeals' decision in this case is wholly consistent with this Court's precedent. First, Petitioner's "injury" originated from CIMRO's alleged failure "to follow proper statutory and regulatory procedures when it found him in violation of certain quality of care requirements." Pet. App. 2a. Here, as in *Chilicky* and *Bush*, "the harm resulting

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[6] Recently, in *FDIC* v. *Meyer*, 114 S. Ct. 996 (1994), this Court unanimously refused to allow a *Bivens* claim to go forward directly against a federal agency, noting that its recent decisions have "'responded cautiously to suggestions that *Bivens* remedies be extended into new contexts.'" *Id.* at 1005 (quoting *Chilicky*, 487 U.S. at 421). This Court also observed that caution should be exercised when recognizing new *Bivens* actions because of the potentially enormous financial burden to the federal government that these remedies could create. *Id.* at 1006.

from the alleged constitutional violation can in neither case be separated from the harm resulting from the denial of the statutory right." *Chilicky*, 487 U.S. at 428. In addition, as in *Chilicky* and *Bush*, Congress has created an extensive procedure to review the PROs' conduct. See pp. 2-5 *supra*. This multi-level scheme is almost identical to the one the *Chilicky* Court concluded was sufficient to bar a *Bivens* action. It is also more extensive than the scheme the *Bush* Court determined was adequate to bar a claim for money damages. See *Chilicky*, 487 U.S. at 425. This review scheme also shares many elements with the one that the Tenth Circuit in *Hilst* v. *Bowen*, 874 F.2d 725, 727-28 (10th Cir. 1989), determined was a "comprehensive remedy . . . provided to physicians when their right to participate in the Medicare program is suspended," and which precluded a *Bivens* claim for damages resulting from a physician's suspension from the program. Given the comprehensiveness of the scheme governing PRO conduct, it is apparent that Congress intended the statutory and regulatory Medicare framework to be the exclusive remedy for claims arising out of the PRO system. The court of appeals therefore correctly determined that, as a matter of law, a *Bivens* action for money damages is unavailable to Petitioner.[7]

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[7] Although the court of appeals did not reach the issue, CCFMC and CIMRO also argued that the judgment of the district court could be affirmed on the ground that Respondents enjoy absolute immunity for claims arising from their review of physicians in the Medicare program. See, *e.g.*, *Kwoun* v. *Southeast Missouri Prof. Standards Review Org.*, 811 F.2d 401, 409 (8th Cir. 1987) (recognizing absolute immunity for PROs), cert. denied, 486 U.S. 1022 (1988). This absolute immunity for PROs was a separate and independent ground to affirm the judgment of the district court. The existence of this other basis to support the decision of the

## II. *PETITIONER HAD ACCESS TO CONGRESS'* CAREFULLY WROUGHT ADMINISTRATIVE REVIEW SCHEME

Petitioner does not really dispute that the extensive scheme governing PRO reviews would preclude him from bringing a *Bivens* action for money damages. Indeed, he himself describes the scheme as "comprehensive," "elaborate," and "extensive." Pet. 5, 7, 8, 9; see also Pet. 10 ("Congress did construct a system which would normally protect individuals like Petitioner with meaningful safeguards and remedies").

Instead, Petitioner argues that this case is distinguishable because Respondents allegedly prevented him from getting the benefit of the administrative review procedures. According to Petitioner, "[t]he only thing that [he] wanted was to appeal Respondents' decision to restrict his ability to care for Medicare patients" and "Respondents refused to allow him to do so." Pet. 5.

For several reasons, this argument does not stand up to scrutiny. First, as this Court has held, "[w]hen the design of a Government program suggests that Congress has provided what it considers adequate remedial mechanisms for constitutional violations that may occur in the course of its administration," a *Bivens* remedy will not be created. *Chilicky*, 487 U.S. at 423. As demonstrated above, Congress has created an exhaustive set of procedures to review the actions of PROs. In light of the obvious care that Congress has brought to this issue there is no basis for Petitioner to argue that a remedy for money damages should be engrafted onto Congress' scheme. *Id.* at 429.

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district court is another reason for denying Petitioner's request for certiorari.

*Second, Petitioner's claim that he was barred from the* remedial scheme is simply not true. As both the court of appeals and the district court concluded, Petitioner could have sought to demand Respondents' compliance with the scheme, if he believed that he was wrongfully denied access to it. Although this remedy would not have provided Petitioner the money damages that he wants in this lawsuit, it could have allowed him to demand that the PROs follow the statute and regulations, which would alleviate the precise injury that he claims he received.

As the lower courts observed — and as Petitioner appears to concede (Pet. 9) — Petitioner could have sought to require Respondents to follow the proper administrative procedures by seeking mandamus under 28 U.S.C. § 1361. This mandamus relief would not have given Petitioner the money damages that he seeks, but it presumably would have obtained for him the procedures that he claims he is due.

In addition, as CCFMC argued to the court of appeals, if Petitioner was dissatisfied with the conduct of the PROs, he had the opportunity to gain immediate redress by bypassing those organizations and contacting HHS directly with his complaints. HHS, in turn, could have provided him with the relief he seeks either by enforcing the terms of the PROs' contracts (if HHS concluded there had been a violation of those contracts) or by invoking 42 U.S.C. § 1320c-2, terminating the contracts (again, assuming HHS found a violation), and transferring the PROs' responsibilities to another organization. See *Kwoun* v. *Southeast Missouri Prof. Standards Review Org.*, 811 F.2d 401, 409 (8th Cir. 1987), cert. denied, 486 U.S. 1022 (1988).

Finally, Petitioner has taken the position throughout this litigation that he has exhausted his administrative remedies. See 1st Am. Compl. at Ct. II, ¶ 16 ("The Plaintiff. . . has

exhausted all administrative appeal remedies"); Pet. App. 5a-6a. Taking Petitioner at his word, if he had exhausted his remedies he presumably could have sought judicial review of his situation through 42 U.S.C. § 405(g) and 42 U.S.C. § 1320c-5(b)(4). Although this review would not have allowed the money damages provided through a *Bivens* action,[8] it would have provided relief within the bounds of the statutory scheme created by Congress, and would bar a *Bivens* claim. See *Hilst*, 874 F.2d at 727-28.

Petitioner's only response is to assert that it is "unrealistic to presume" that he or others would bring a mandamus action. Pet. 9. However, he does not explain why it is more unrealistic to think that a person would bring a mandamus action (or seek administrative routes of review) than to think that he or she would bring a *Bivens* claim. Filing a *Bivens* action is arguably much more difficult than taking a grievance to HCFA officials, and certainly no easier than other types of litigation such as mandamus or review under section 405(g). But, in the end, this question of ease of use is beside the point. Under *Chilicky*, 487 U.S. at 423, the relevant inquiry is whether or not Congress provided the Petitioner with what Congress believed to be a sufficient remedial scheme. Once Congress established this scheme, whether its remedies would fully compensate Petitioner and whether its

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[8] Section 405(g) is a mechanism whereby a litigant may challenge the constitutionality of actions taken under the Social Security Act. See *Mathews* v. *Eldridge*, 424 U.S. 319, 332 (1976). The statute, however, does not provide for money damages against officials responsible for unconstitutional conduct. See also *Chilicky*, 487 U.S. at 424-25 (claimants whose benefits are restored through the administrative process lack standing to invoke the Constitution under the statute's administrative review provision); *Hilst*, 874 F.2d at 727-28.

procedures would be easy or difficult to use do not figure into the analysis.

Petitioner also argues that he should receive a *Bivens* remedy because "[f]orcing Respondents to follow Congress' theme [*sic*] at this point is moot." Pet. 5. However, the record reflects that the Corrective Action Plan Petitioner objects to was suggested in August 1989, and Petitioner did not contact HCFA with his complaints until 1991 and did not file any legal challenge to his situation until 1992, after the CAP had closed. The only reason petitioner is in desperation now is that he failed to seek other remedies in a timely fashion, and the CAP ended. Surely Petitioner's failure to take advantage of the comprehensive remedial scheme in a timely fashion cannot be grounds for allowing him a *Bivens* remedy after the fact. Giving him relief in this situation would be an incentive *not* to follow the carefully wrought system that Congress has created.

## III. NO DISAGREEMENT EXISTS AMONG THE LOWER COURTS

Petitioner also claims that the Seventh Circuit's opinion conflicts with the decisions of the Federal Circuit in *Ysasi* v. *Rivkind*, 856 F.2d 1520 (Fed. Cir. 1988), and the Eighth Circuit in *Glasgow* v. *United States Drug Enforcement Administration*, 12 F.3d 795 (8th Cir. 1993). No conflict exists among these decisions.

First, it should be emphasized that neither *Glasgow* nor *Ysasi* discusses the Social Security Act or the peer review system under the Medicare program. To the extent that these cases analyze other statutes with distinct remedial schemes, they cannot call into question the court of appeals' decision that the comprehensive remedial scheme governing PRO reviews bars Petitioner's *Bivens* claim.

In addition, nothing in the reasoning of these cases conflicts with the Seventh Circuit's opinion. In *Glasgow*, the sum total of the discussion of *Chilicky* is the court's refusal to affirm the district court's summary conclusion that the forfeiture remedies under the Tariff Act were sufficiently comprehensive to bar a *Bivens* claim. *Glasgow*, 12 F.3d at 799. Given the brief discussion of *Chilicky* in the Eighth Circuit's opinion, it is simply puzzling why Petitioner believes that *Glasgow* demonstrates a division among the circuits.[9]

*Ysasi* likewise does not conflict with the Seventh Circuit's opinion. *Ysasi* does indeed contain language stating that a *Bivens* remedy may be available when the plaintiff is unable to pursue alternative remedies. However, leaving aside whether this is an accurate statement of the law, this language does not assist Petitioner.

First, as discussed above, Congress created an intricate and comprehensive remedial mechanism governing peer review under the Social Security Act, and thereby precluded

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[9] To the extent it is even relevant to this case, *Glasgow* is consistent with the Seventh Circuit's opinion. Both in this case and in *Glasgow*, the court applied *Chilicky* to determine whether a statutory scheme's remedies were sufficiently comprehensive to demonstrate that Congress intended to bar an action for money damages. Here, the Seventh Circuit, following *Chilicky*, decided that the detailed remedies of the Medicare program indicated that Congress precluded an action for money damages. See Pet. App. 7a-11a. In *Glasgow*, the court decided that it could not determine without further analysis whether the protections of a different statute prevented a *Bivens* remedy. See *Glasgow*, 12 F.3d at 799. The decisions simply apply the same principles to different factual and legal settings. There is nothing in their reasoning that is in conflict.

Petitioner from bringing a *Bivens* claim even if that mechanism did not give him complete relief for his alleged injuries. See *Chilicky*, 487 U.S. at 429. In addition, as both the district court and the court of appeals determined, Petitioner could have sought relief within the statutory scheme that Congress created, if only he had pursued these remedies. In fact Petitioner himself admits that he could have sought mandamus to gain the appeals that he claims he was denied.

Also, *Ysasi* arose in a factual setting that is markedly different from the one in this case. The *Ysasi* court based much of its analysis on the fact that the truck that the plaintiff was seeking to recover had been transferred irremediably to a lienholder before Ysasi could have filed his administrative claims. The court concluded that once possession of the truck had been transferred, "[i]t would have been pointless for Ysasi" to pursue any alternative remedies. *Ysasi*, 856 F.2d at 1527.

Here, unlike in *Ysasi*, it did not become "pointless" for Petitioner to try and gain relief through the administrative scheme. Petitioner accepted and worked under the CAP for many months before he raised his first objection to it. At any point during this period the Petitioner could have sought review of his situation either by contacting HHS or seeking judicial review through mandamus or an action under section 405(g). The facts that Petitioner slept on his rights and did not seek relief until years later should not allow him to sue the Respondents for money damages.

Indeed, it is Petitioner's contentions that, if adopted, would conflict with existing precedents. Petitioner advocates making available wide-ranging remedies for money damages against persons administering the Social Security program who "disregard the rules and regulations Congress enacts governing that agency." Pet. 8. *Chilicky*, however, decided conclusively

that money damages are not available in these circumstances. Petitioner seeks to ignore this precedent by bringing a damages claim in a situation where Congress has affirmatively barred this remedy.

Also, as has been recently reiterated, this Court has "'responded cautiously to suggestions that *Bivens* remedies be extended into new contexts.'" *FDIC* v. *Meyer*, 114 S. Ct. 996, 1005 (1994) (quoting *Chilicky*, 487 U.S. at 421). Petitioner's attempt to inject claims for money damages into the Social Security system presents the possibility of thousands of lawsuits being brought seeking to impose personal liability on government employees. Besides clogging the courts, the mere threat of these lawsuits "would undoubtedly lead to new difficulties and expense in recruiting administrators for the programs Congress has established." *Chilicky*, 487 U.S. at 425. In addition, the funds spent both to defend these claims and to pay for any judgments would impose a new and significant burden on the Treasury. See *Meyer*, 114 S. Ct. at 1006 (noting that the Court has refused to authorize *Bivens* remedies which implicate the "federal fiscal policy" by "creating a potentially enormous financial burden for the Federal Government"). For these reasons, presumably, Congress created an exclusive remedial scheme to deal with all claims that arise from the Social Security program. Once Congress made this decision, it affirmatively barred the *Bivens* remedy Petitioner now seeks.

## CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

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JULY 1994

# APPENDIX

# RELEVANT STATUTES AND REGULATIONS

## Statutes

### 28 U.S.C. § 1254(1) (1988)

§ 1254. Courts of appeals; certiorari; certified questions

Cases in the courts of appeals may be reviewed by the Supreme Court by the following methods:

(1) By writ of certiorari granted upon the petition of any party to any civil or criminal case, before or after rendition of judgment or decree;

### 28 U.S.C. § 1361 (1988)

§ 1361. Action to compel an officer of the United States to perform his duty

The district courts shall have original jurisdiction of any action in the nature of mandamus to compel an officer or employee of the United States or any agency thereof to perform a duty owed to the plaintiff.

### 42 U.S.C. § 1395y(g) (1988)

(g) Contracts with utilization and quality control peer review organizations

The Secretary shall, in making the determinations under paragraphs (1) and (9) of subsection (a) of this section, and for the purposes of promoting the effective, efficient, and economical delivery of health care services, and of promoting the quality of services of the type for which payment may be made under this subchapter, enter into contracts with utilization and quality control peer review

organizations pursuant to part B of subchapter XI of this chapter.

**42 U.S.C. § 1320c-2(c) (1988)**

(c) Terms of contract

Each contract with an organization under this section shall provide that--

(1) the organization shall perform the functions set forth in section 1320c-3(a) of this section, or may subcontract for the performance of all or some of such functions (and for purposes of paragraphs (2) and (3) of subsection (b) of this section, a subcontract under this paragraph shall not constitute an affiliation with the subcontractor);

(2) the Secretary shall have the right to evaluate the quality and effectiveness of the organization in carrying out the functions specified in the contract;

(3) the contract shall be for an initial term of three years and shall be renewable on a triennial basis thereafter;

(4) if the Secretary intends not to renew a contract, he shall notify the organization of his decision at least 90 days prior to the expiration of the contract term, and shall provide the organization an opportunity to present data, interpretations of data, and other information pertinent to its performance under the contract, which shall be reviewed in a timely manner by the Secretary;

(5) the organization may terminate the contract upon 90 days notice to the Secretary;

(6) the Secretary may terminate the contract prior to the expiration of the contract term upon 90 days notice to the organization if the Secretary determines that--

(A) the organization does not substantially meet the requirements of section 1320c-1 of this title; or

(B) the organization has failed substantially to carry out the contract or is carrying out the contract in a manner inconsistent with the efficient and effective administration of this part, but only after such organization has had an opportunity to submit data and have such data reviewed by the panel established under subsection (d) of this section;

(7) the Secretary shall include in the contract negotiated objectives against which the organization's performance will be judged, and negotiated specifications for use of regional norms, or modifications thereof based on national norms, for performing review functions under the contract; and

(8) reimbursement shall be made to the organization on a monthly basis, with payments for any month being made not later than 15 days after the close of such month.

In evaluating the performance of utilization and quality control peer review organizations under contracts under this part, the Secretary shall place emphasis on the performance of such organizations in educating providers and practitioners (particularly those in rural areas) concerning the review process and criteria being applied by the organization.

**42 U.S.C. § 1320c-5(a) & (b) (1988)**

§ 1320c-5. Obligations of health care practitioners and providers of health care services; sanctions and penalties; hearings and review

(a) Assurances regarding services and items ordered or provided by practitioner or provider

It shall be the obligation of any health care practitioner and any other person (including a hospital or other health care

facility, organization, or agency) who provides health care services for which payment may be made (in whole or in part) under this chapter, to assure, to the extent of his authority that services or items ordered or provided by such practitioner or person to beneficiaries and recipients under this chapter--

(1) will be provided economically and only when, and to the extent, medically necessary;

(2) will be of a quality which meets professionally recognized standards of health care; and

(3) will be supported by evidence of medical necessity and quality in such form and fashion and at such time as may reasonably be required by a reviewing peer review organization in the exercise of its duties and responsibilities.

(b) Sanctions and penalties; hearings and review

(1) If after reasonable notice and opportunity for discussion with the practitioner or person concerned, any organization having a contract with the Secretary under this part determines that such practitioner or person has--

(A) failed in a substantial number of cases substantially to comply with any obligation imposed on him under subsection (a) of this section, or

(B) grossly and flagrantly violated any such obligation in one or more instances,

such organization shall submit a report and recommendations to the Secretary. If the Secretary agrees with such determination, and determines that such practitioner or person, in providing health care services over which such organization has review responsibility and for which payment (in whole or in part) may be made under this chapter, has

demonstrated an unwillingness or a lack of ability substantially to comply with such obligations, the Secretary (in addition to any other sanction provided under law) may exclude (permanently or for such period as the Secretary may prescribe) such practitioner or person from eligibility to provide services under this chapter on a reimbursable basis. If the Secretary fails to act upon the recommendations submitted to him by such organization within 120 days after such submission, such practitioner or person shall be excluded from eligibility to provide services on a reimbursable basis until such time as the Secretary determines otherwise.

(2) A determination made by the Secretary under this subsection to exclude a practitioner or person shall be effective on the same date and in the same manner as an exclusion from participation under the programs under this chapter becomes effective under section 1320a-7(c) of this title, and shall remain in effect until the Secretary finds and gives reasonable notice to the public that the basis for such determination has been removed and that there is reasonable assurance that it will not recur.

(3) In lieu of the sanction authorized by paragraph (1), the Secretary may require that (as a condition to the continued eligibility of such practitioner or person to provide such health care services on a reimbursable basis) such practitioner or person pays to the United States, in case such acts or conduct involved the provision or ordering by such practitioner or person of health care services which were medically improper or unnecessary, an amount not in excess of the actual or estimated cost of the medically improper or unnecessary services so provided. Such amount may be deducted from any sums owing by the United States (or any instrumentality thereof) to the practitioner or person from whom such amount is claimed.

(4) Any practitioner or person furnishing services described in paragraph (1) who is dissatisfied with a determination made by the Secretary under this subsection shall be entitled to reasonable notice and opportunity for a hearing thereon by the Secretary to the same extent as is provided in section 405(b) of this title, and to judicial review of the Secretary's final decision after such hearing as is provided in section 405(g) of this title.

(5) Before the Secretary may effect an exclusion under paragraph (2) in the case of a provider or practitioner located in a rural health manpower shortage area (HMSA) or in a county with a population of less than 70,000, the provider or practitioner adversely affected by the determination is entitled to a hearing before an administrative law judge (described in section 405(b) of this title) respecting whether the provider or practitioner should be able to continue furnishing services to individuals entitled to benefits under this chapter, pending completion of the administrative review procedure under paragraph (4). If the judge does not determine, by a preponderance of the evidence, that the provider or practitioner will pose a serious risk to such individuals if permitted to continue furnishing such services, the Secretary shall not effect the exclusion under paragraph (2) until the provider or practitioner has been provided reasonable notice and opportunity for an administrative hearing thereon under paragraph (4).

**Regulations**

**42 C.F.R. § 1004.1(b)(1988)**

§ 1004.1 Scope and definitions.

(b) *Definitions.* As used in this part, unless the context indicates otherwise:

*Gross and flagrant violation* means a violation of an obligation has occurred in one or more instances which presents an imminent danger to the health, safety or well-being of a Medicare beneficiary or places the beneficiary unnecessarily in high-risk situations.

**42 C.F.R. § 1004.40 (1988)**

§ 1004.40 Action on identification of a violation.

When a PRO identifies a violation, it must determine the nature of the violation.

(a) If the PRO determines the violation as one that is gross and flagrant, it must proceed in accordance with § 1004.50.

(b) If the PRO determines the violation as a substantial violation in a substantial number of cases it must send the practitioner or other person a written initial notice of the identification of a violation containing the following information:

(1) The obligation involved.

(2) The situation, circumstances, or activity that resulted in a violation.

(3) The authority and responsibility of the PRO to report violations of obligations.

(4) At the discretion of the PRO, a suggested method for correcting the situation and a time period for corrective action.

(5) The sanction that the PRO could recommend to the OIG if the violation continues.

(6) An invitation to submit additional information to or discuss the problem with representatives of the PRO within 20 days of receipt of the notice. The date of receipt is presumed to be five days after the date on the notice, unless there is a reasonable showing to the contrary.

(7) A summary of the information used by the PRO in arriving at its determination of a violation of an obligation.

**42 C.F.R. § 1004.50 (1988)**

§ 1004.50 Action on determination of a violation.

(a) *Written notice.* The PRO must give written notice to the practitioner or other person if it determines that--

(1) A substantial violation has occurred in a substantial number of cases; or

(2) A violation is gross and flagrant in one or more cases.

(b) *Contents.* The notice must contain the following information:

(1) The determination of a violation.

(2) The obligation violated.

(3) The basis for the determination.

(4) The sanction the PRO will recommend to the OIG.

(5) The right of the practitioner or other person to submit to the PRO within 30 days of receipt of the notice, additional information or a written request for a meeting with the PRO to review and discuss the determination, or both. The date of receipt is presumed to be five days after the date on the notice, unless there is a reasonable showing to the contrary.

(6) A copy of the material used by the PRO in arriving at its determination.

(c) *Review of PRO determination.*

(1) The PRO may, on the basis of additional information received, affirm, modify, or reverse its determination.

(2) The PRO must give written notice to the practitioner or other person, of any action it takes as a result of the additional information received, as specified in § 1004.60.

**42 C.F.R. § 1004.60 (1988)**

§ 1004.60 Final PRO determination of a violation.

If the issue is not resolved to the PRO's satisfaction as specified in § 1004.50(c), the PRO must--

(a) Submit its report and recommendation to the OIG; and

(b) Send the affected practitioner or other person a concurrent final notice, with a copy of the PRO report that is being forwarded to the OIG, advising that--

(1) The PRO recommendation has been submitted to the OIG;

(2) The practitioner or other person has 30 days from receipt of this final notice to submit any additional written material or documentary evidence to the OIG at its central

office location. The date of receipt is presumed to be five days after the date on the notice, unless there is a reasonable showing to the contrary; and

(3) Due to the 120-day statutory requirement specified at § 1004.90(e), the period for submitting additional information will not be extended and any material received by the OIG after the 30-day period will not be considered.

**42 C.F.R. § 1004.70 (1988)**

§ 1004.70 PRO report to OIG.

(a) *Manner of reporting.* If the PRO determines that a substantial violation has occurred in a substantial number of cases or that a gross and flagrant violation has occurred, it must submit a report and recommendation to the OIG at the regional office with jurisdiction.

(b) *Content of report.* The PRO report must include the following information--

(1) Identification of the practitioner or other persons and when applicable, the name of the director, administrator, or owner of the entity involved;

(2) The type of health care services involved;

(3) A description of each failure to comply with an obligation, including specific dates, places, circumstances, and any other relevant facts;

(4) Pertinent documentary evidence;

(5) Copies of written correspondence and written summaries of oral exchanges with the practitioner or other person regarding the violation;

(6) The PRO's determination that an obligation under section 1156(a) of the Act has been violated and that the violation is substantial and has occurred in a substantial number of cases or is gross and flagrant;

(7) The professional qualifications of the PRO's reviewers' and

(8) The PRO's sanction recommendation.

(c) *PRO Recommendation.* The PRO must specify in its report--

(1) The sanction recommended;

(2) The amount of the monetary penalty recommended, if applicable;

(3) The period of exclusion recommended, if applicable; and

(4) A recommendation as to whether the practitioner or other person is unable or unwilling substantially to comply with the obligation that was violated.

**42 C.F.R. § 1004.80 (1988)**

§ 1004.80 Basis for recommended sanction.

The PRO's specific recommendation must be based on a consideration of--

(a) The type of offense involved;

(b) The severity of the offense;

(c) The deterrent value;

(d) The practitioner's or other person's previous sanction record;

(e) The availability of alternative sources of services in the community; and

(f) Any other factors that the PRO considers relevant (for example, the duration of the problem).

**42 C.F.R. § 1004.90 (1988)**

§ 1004.90 Acknowledgement and review of report.

(a) *Acknowledgement.* The OIG will inform the PRO of the date it received the PRO's report and recommendation.

(b) *Review.* The OIG will review the PRO report and recommendation to determine whether--

(1) The PRO is following its procedures;

(2) A violation has occurred; and

(3) The practitioner or other person has demonstrated an unwillingness or lack of ability substantially to comply with an obligation.

(c) *Rejection of the PRO recommendation.* If the OIG decides that a sanction is not warranted, it will notify the PRO that recommended the sanction and the affected practitioner or other person that the recommendation is rejected.

(d) *Decision of sanction.* If the OIG decides that a violation of obligations has occurred, it will determine the appropriate sanction by considering--

(1) The recommendation of the PRO;

(2) The type of offense;

(3) The severity of the offense;

(4) The previous sanction record of the practitioner or other person;

(5) The availability of alternative sources of services in the community;

(6) Any prior problems the Medicare carrier or intermediary has had with the practitioner or other person;

(7) Whether the practitioner or other person is unable or unwilling to comply substantially with the obligations; and

(8) Any other matters relevant to the particular case.

(e) *Exclusion sanction.* If the PRO submits a recommendation for exclusion to the OIG, and a determination is not made by the 120th day after actual receipt by the OIG, the exclusion sanction recommended will become effective and the OIG will provide notice in accordance with § 1004.100(f).

(f) *Monetary penalty.* If the PRO recommendation is to assess a monetary penalty, the 120-day provision does not apply and the OIG will provide notice in accordance with § 1004.100(a) through (e).

**42 C.F.R. § 1004.130 (1988)**

§ 1004.130 Appeal rights.

(a) *Right to administrative review.*

(1) A practitioner or other person dissatisfied with an OIG determination or an exclusion that results from a determination not being made within 120 days is entitled to a hearing before an Administrative Law Judge and may also request a review of that decision by the Appeals Council in accordance with Part 498 of this title.

(2) Due to the 120-day statutory requirement specified at § 1004.90(e) of this part, the following limitations apply:

(i) The period for submitting additional information will not be extended.

(ii) Any material received by the OIG after the 30-day period allowed, will not be considered and will not be subject to review by the Administrative Law Judge and the Appeals Council.

(3) The OIG's determination continues in effect unless reversed by a hearing decision.

(b) *Right to judicial review.* Any practitioner or other person dissatisfied with a decision of the Appeals Council or an administrative law judge (if a request for Appeals Council review is denied) may file a civil action in accordance with the provisions of section 205(g) of the Act.

Supreme Court, U.S.
FILED
JUL 6 1994
OFFICE OF THE CLERK

No. 93-1944

IN THE
# Supreme Court of the United States
OCTOBER TERM, 1994

ABBAS ASSAR, M.D.,
*Petitioner,*

v.

CRESCENT COUNTIES FOUNDATION FOR MEDICAL CARE,
and
CENTRAL ILLINOIS MEDICAL REVIEW ORGANIZATION,
*Respondents.*

**On Petition for a Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit**

## BRIEF *AMICUS CURIAE* OF THE ILLINOIS STATE MEDICAL SOCIETY IN SUPPORT OF PETITIONER

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**On Petition for a Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit**

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## BRIEF *AMICUS CURIAE* OF THE ILLINOIS STATE MEDICAL SOCIETY IN SUPPORT OF PETITIONER

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### INTRODUCTION

This brief is submitted by *amicus curiae*, the Illinois State Medical Society ("ISMS") in support of Appellee, Abbas Assar's M.D., Petition for a Writ of Certiorari. ISMS believes it important for the United States Supreme Court to take this case on review to clearly establish that a cause of action for monetary damages is available for an individual whose constitutional rights are violated when the United States Government through officers, employees or agents violates or fails to implement the statutory and regulatory mandates of a federal program and prevents

the individual from obtaining any form of administrative and judicial review provided under the statutory mandates.

The United States District Court for the Central District of Illinois dismissed this case for lack of subject matter jurisdiction because it found that a *Bivens* remedy is not available to the plaintiff as a matter of law. *Assar v. Crescent Counties Foundation for Medical Care and Central Illinois Medical Review Organization*, No. 92-2161 (C.D. Ill. Oct. 6, 1992). The United States Court of Appeals for the Seventh Circuit affirmed the district court's dismissal of the case finding "No *Bivens* remedy is available to Assar in light to the comprehensive remedial scheme set forth in the statute and regulations." *Assar v. Crescent Counties Foundation for Medical Care and Central Illinois Medical Review Organization*, No. 92-3678, Slip Op. at 11, (7th Cir. Dec. 29, 1993). Petitioner filed his Petition for Writ of Certiorari in this case June 6, 1994.

ISMS has sought the acceptance for filing this *amicus curiae* brief from Crescent Counties Foundation for Medical Care ("CCFMC") and Central Illinois Medical Review Organization, ("CIMRO") Respondents. The affirmative responses of these organizations have been filed with the Clerk of this Court.

## SUMMARY OF ARGUMENT

This Petition for Writ of Certiorari should be granted by the United States Supreme Court to determine whether federal officials can ignore statutory and regulatory mandates and violate an individual's constitutional rights and not be subject to a cause of action for monetary relief under *Bivens v. Six Unknown Agents of Federal Bureau of Narcotics*, 403 U.S. 388 (1971). ISMS believes that the appellate court's decision affirms the alleged unconstitutional deprivation of Petitioner's property without due process of law. This decision has devastating effects on the Petitioner, on physicians and on the medicare program.

Physician participants have been told by the appellate court that peer review organizations can do anything they desire, without any basis in fact, even the deprivation of a physician's livelihood. Physicians cannot defend themselves in any way. Further, this appellate court's decision creates a conflict between the United States Court of Appeals for the Seventh Circuit, United States Court of Appeals for the Eighth Circuit and the United States Court of Appeals for the Federal Circuit on this issue.

The United States Courts of Appeals for the Eighth Circuit and the Federal Circuit have both determined that a *Bivens* claim is warranted when a federal official obstructs the comprehensive statutory and regulatory safeguards established by Congress and the agency. *Glasgow v. United States Drug Enforcement Administration*, 12 F.3d 795 (8th Cir. 1993) and *Ysasi v. Rivkind*, 856 F.2d 1520 (Fed. Cir. 1988).

## ARGUMENT

ISMS believes that an important point of law is at question in this case. This important point is whether officials, employees or agents for the federal government, can ignore statutory and regulatory mandates and deny or severely restrict participation in a federal program without affording the due process rights provided for under the law and be above a claim for monetary relief under *Bivens v. Six Unknown Named Agents of Federal Bureau of Narcotics*, 403 U.S. 388 (1971).

Being a professional association representing approximately 18,000 Illinois physicians, ISMS has an interest and a unique perspective of the implications of the resolution of this issue, beyond the effect on the parties in this particular cause of action. This issue has far reaching implications in the health care industry. In an era where the marketplace is drastically changing and managed care is coming to the forefront as the dominant methodology for providing private and public health care

insurance or funding, health care providers are finding themselves excluded from participation arbitrarily and capriciously without any due process procedures to protect their livelihood. If no rights to damages exist in a federally maintained system such as here, trust and respect for the managers of the system will diminish as will the willingness to participate.

A physician's participation in the federal medicare program is clearly a property interest which cannot be deprived by the federal government without due process of law. *Northlake Community Hospital v. United States*, 654 F.2d 1234, 1241-3 (7th Cir. 1981). The United States Congress through the Social Security Act and the Secretary of the Department of Health and Human Services ("Secretary") through regulations have established a comprehensive statutory and regulatory scheme which includes specific provisions requiring the Secretary to provide due process protections for those persons who participate in the medicare program including physicians. 42 U.S.C. § 1320c-5(b)(1) (1991); 42 C.F.R. § 1004.10-1004.100 and Part 498 (1991).

These protections, as identified by the Appellate and District Courts, consist of a comprehensive statutory and regulatory scheme to provide administrative and judicial review which require peer review organizations to conduct investigations and to submit reports and recommendations to the Secretary. 42 U.S.C. § 1320c-5 (1991); 42 C.F.R. 1004.60-80 (1991). The Secretary then may sanction a provider after the opportunity for a hearing. 42 C.F.R. § 1004.100 and 42 C.F.R. 498 (1991). The Appellants, however, allegedly failed to follow this statutory and regulatory scheme and instead implemented a non-statutory and non-regulatory procedure circumventing this scheme.

The appellate and district court decisions, in essence, send a message to federal officials acting under color of law that they can ignore statutory and regulatory man-

dates. This includes due process requirements intended to protect participants in federal programs for violation of their constitutional rights. They can arbitrarily and unreasonably restrict or deny participation in the program without having to explain the reasons for such restrictions and without allowing the participant a reasonable opportunity to contest the allegations or accuracy of their information or the validity of their conclusions.

With respect to the medicare program, the appellate and district court decisions send the message to physicians and other health care providers throughout the United States that the courts will allow peer review organizations to flagrantly ignore statutorily and regulatory due process protections.

Petitioner's First Amended Complaint sufficiently plead clear allegations of violations of the comprehensive and regulatory requirements of the Medicare program to establish a cause of action for monetary damages against federal officials for constitutional violations to allow the District Court to adjudicate the merits of the allegations. (1st Am. Compl., App. Brief A-2-52) These alleged violations, in part, consist of the following:

- CIMRO determined Petitioner committed a gross and flagrant quality of care deficiency involving a medicare patient and did not provide Petitioner with a written notice of the determination.
- CIMRO imposed practice restrictions and limitations (sanctions) on Petitioner.
- CIMRO failed to report the determinations to the Office of the Inspector General (OIG)
- CIMRO made false, defamatory and misleading statements concerning Petitioner to third parties.
- CIMRO acted maliciously and retaliated against Petitioner for successful defense of previous CIMRO actions.

- CIMRO and the Secretary refused all attempts to appeal sanctions by Petitioner.
- CIMRO refused to disclose information about this matter to Petitioner.

(1st Am. Comp., App. Brief, A3-6)

The logical and unfortunately expected result of violations of the nature plead in this case is the significant or complete deprivation of a physician's livelihood. Physicians professional life and livelihood is based almost entirely upon their peers, hospital administrations and patient perceptions of the ability to provide the highest quality of care. When a physician's reputation is tarnished whether validly or not, the physician's ability to practice is significantly effected.

Lies, innuendo and false gossip can destroy the professional career of a physician. When these things happen, the damage is already done and restoring your good name or reputation is extremely difficult. In private acitons, physicians have the ability to resort to initiating causes of action for defamation, invasion of privacy, or restriction of trade.

Federal officials who are required to execute and uphold the laws of the United States may at times also disseminate lies, innuendo and falsehoods and thus violate statutory and regulatory mandates. Congress attempts to protect the public from these types of actions by federal officials through enactment of statutory due process requirements. When federal officials violate statutory and regulatory mandates, they should not be allowed to hide behind the mere existence of the statutory and regulatory mandates in statute books to prevent redress of the injustices committed by such federal officials.

Additionally, the appellate and district court decisions undermine the effectiveness and ability of peer review organizations such as Respondents to perform their duties. As peer review organizations, their paramount

duty is to review the care provided to medicare recipients and ensure that the care is provided within the guidelines set forth in the Social Security Act. 42 U.S.C. § 1320c-5 (1991) This peer review function is best conducted with the voluntary participation by all parties.

To effectively tell the physicians of the State of Illinois that CCFM and CIMRO can ignore the statutory and regulatory requirements of the medicare program and implement procedures outside these requirements by sanctioning physicians while at the same time not allowing physicians any opportunity for a hearing to fully delineate their views on the matter will severely impact the medicare program, individual physicians, and the peer review process itself.

Congress has in many statutory programs, of the need for spoken federal officials to explain to people participating in programs what their rights are for appeal of agency decisions. Congress' understanding of the information and knowledge of persons before agencies has resulted in many programs setting forth detailed information on what must actually be provided to a person regulated by the agency.

As in this case, this information includes informing the individual's regulated of their rights to comment or appeal, if any, when an adverse agency decision is made. 42 U.S.C. § 1320c-5 (1991); 42 C.F.R. § 1004.30 (1991). It stands to reason that individuals should be able to rely upon the agencies meeting its statutory mandate and informing the parties of their rights and responsibilities. Absent the ability to rely upon government information, the credibility of government programs is severely undermined and the ability of government to function is crippled.

CIMRO in this instance allegedly conducted an investigation under the statutory and regulatory mandates and its contracts with the Secretary, but instead of submitting

its recommendations for sanction to the Secretary for review and possible discipline as required by law, CIMRO proceeded to discipline the Petitioner itself. (1st Am. Compl. at Ct. I, § 7-10, App. Brief A3-A4) CIMRO did not have the authority to discipline the Petitioner. (1st Am.Compl. at Ct. I, § 13, App. Brief A4) CIMRO allegedly entered into a sanctioning process which was not set forth in the statute or the regulations.

The sanctions imposed and this unlawful sanctioning process were allegedly not explained in writing to the Petitioner as mere recommendations to the Secretary. Imposition of sanctions are required to be provided to participants in writing. 42 C.F.R. 1004.70 (1991).

This sanction was the establishment of a corrective action plan. The corrective action plan was apparently established for a time period of two years. If the sanctions were successfully complied with, CIMRO would apparently make no recommendations to the Secretary.

This process did not include informing the Petitioner that the Petitioner did not have to participate in this unlawful practice. This process did not even include providing the Petitioner with a copy of this "corrective action plan". This informal process may have been created through amendments to the CCFMC contract with the Secretary (Appellees App. Brief Appendix A50-51). This is an alleged instance where the Secretary conspired with its contractual agent, CIMRO, to deprive this Petitioner of his rights under the statutory and regulatory scheme.

As pointed out by both Petitioner and Respondent in their briefs before the United States Court of Appeals for the Seventh Circuit, the law was changed to allow this unauthorized sanctioning process. The statute now includes the language authorizing corrective action plans "if appropriate, after the Petitioner or person has been given a reasonable opportunity to enter into and complete a corrected action plan (which may include remedial education), agreed to by the organization, and has failed

successfully to complete such plan". (Public Law 101-508, § 4205(a)(1)(A) (1990)).

This statutory change is clearly evidence that the alleged actions of Respondents were not previously authorized by Congress. This type of activity carried out by federal officials is reprehensible. The United States Congress sets forth the parameters for this federal program including protections against violations of constitutional rights. The agency then adopted the regulations for this program. In this instance, allegedly, by contracting with private entities to be its agents, the government ignored the Congressional mandates and its own regulations.

These circumstances must be closely examined to prevent federal officials from trampling on the rights of individual citizens by not following the laws they are required to uphold and implement. The Supreme Court must determine that enactment of a comprehensive statutory and regulatory scheme by Congress in and of itself does not preclude a cause of action against federal officials for constitutional violations when those same federal officials ignore the comprehensive statutory and regulatory scheme.

## CONCLUSION

ISMS believes that the Petitioner's Petition for a Writ of Certiorari should be granted to resolve the conflict between circuits of the Supreme Court to find that an individual may bring a cause of action for monetary damages when federal officials violate an individual's constitutional rights, and frustrate or ignore a comprehensive statutory and regulatory scheme established to protect those constitutional rights. For these reasons, the Supreme Court should grant the Petition for Writ of Certiorari.

Respectfully submitted,

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